

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-74
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16010									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last ELIZABETH REINOEHL ADAMS					2a. DATE OF DEATH 11 Month 1 Day 68 Year		2b. HOUR 4:25 a.m.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8-21-19		6. AGE (In years lost birthday) 49 YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) North Dakota		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Teacher		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Clarksville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last Frank Reinoehl			15. MOTHER'S MAIDEN NAME First Middle Last Nellie Carman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 214-38-7858		17. INFORMANT Medical Records		Address Montgomery General Hospital, Olney, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of the ovary</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>AND BONE MARROW depression due to X-ray + chemotherapy</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>8 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>1750</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <u>Oct 26, 1968</u> to <u>Nov 1, 1968</u> , that (I) (we) lost the deceased alive on <u>Oct 31, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Chester L. Wagstaff</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>11-1-68</u>			
22d. PHYSICIAN'S NAME (Type) Chester L. Wagstaff, M.D.				22e. ADDRESS Medical Center Sandy Spring, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/3/68		23c. NAME OF CEMETERY OR CREMATORY Woodside		23d. LOCATION (City or Town) (County) (State) Brinklow, Maryland			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.				25a. REC'D BY REGISTRAR DATE NOV 6 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1003

And this is the reason why
I am writing to you
about the money
I have given you
and the money
I have given you
and the money
I have given you

1-1-48 X

Charles King, Manager

TO HOSPITAL () ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
16011		16025										
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last BUSHROD WARREN ALLIN						2a. DATE OF DEATH Month Day Year Nov. 18, 1968			2b. HOUR A.M. 7:20 A.M.			
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH Aug. 28, 1899			6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.						
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street-address) Kensington Gardens San.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Economist - Retired			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5214 Goddard Road				
14. FATHER'S NAME First Middle Last John Allin						15. MOTHER'S MAIDEN NAME First Middle Last Florabella Gritton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16b. SOCIAL SECURITY NO. 213-44-4083		17. INFORMANT Wife		17a. ADDRESS Thelma O. Allin Same as Item 13.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 PYCNOMONIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) PAR KINSONISM										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Days 6 YRS 10 YRS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4500												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from JAN. 1935 to Nov. 1968 , that (I) (we) last saw the deceased alive on Nov 16 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Leo I. Donovan						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11-18-68				
22d. PHYSICIAN'S NAME (Type) LEO I. DONOVAN						22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-20-68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland						
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland						25a. REC'D BY REGISTRAR NOV 20 1968		25b. REGISTRAR'S SIGNATURE McLennan Judge				

2321

$$\lim_{n \rightarrow \infty} \frac{I_n}{V_n} = \frac{\pi^2}{6}$$

16018

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
MORRIS				ALPERT	Nov. 5 1968		10:20 AM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS
M.	W		Feb 16, 1919		49 YRS.		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
N.J.				Montgomery		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
SILVER SPRINGS		HOLY CROSS Hosp		CHEMIST - ENG.		US GOV'T.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MD		MONTG.		SILVER SPRING		2211 Ross Court.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.	
BENJAMIN		SADIE GARDINSKY					
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ADELE ALPERT		2211 Ross Court - S.S. Md.		4369			
PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF			
		Cerebral Vascular Accident		(b)			
		DUE TO, OR AS A CONSEQUENCE OF		(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		331X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from June, 1959, to 11-5, 1968, that (I) (we) last saw the deceased alive on 11-5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22g. REGISTERAR'S SIGNATURE	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
B. DUNZANSKY 450NS		Nov 6/1968		KING DAVID Mem. Garden		FALLS CHURCH Md.	
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. REC'D BY REGISTRAR		24c. DATE	
B. DUNZANSKY 450NS		3501 14th St NW		WASH. D.C.		NOV 7 1968	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's pages, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR Min.	
Robin Aylsworth Anderson						November 2 1968		10:40	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Male		White		8 November 1921		48 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New Jersey		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		The Clinical Center		Supervisor		Corp.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
New Jersey				Wayne		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		102 Maplewood Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Harry Anderson			Ethel Bennett						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT					
No		140-16-4423		The Medical Record Address The Clinical Center, NIH, Bethesda, Md. 20014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Thrombotic material, left anterior descending/</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Septicemia and bilateral bronchopneumonia</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Acute myelogenous leukemia</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
2043									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (a) (this hospital) attended the deceased from <u>15 July</u> , 19 <u>68</u> , to <u>2 Nov</u> , 19 <u>68</u> , that (b) (we) lost the deceased alive on <u>2 November</u> , 19 <u>68</u> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. DATE SIGNED			
<u>Harmon J. Eyre</u>		Harmon J. Eyre, M.D.		The Clinical Center, National Institutes of Health, Bethesda, Md. 20014		3 November 1968			
23a. BURIAL, CREMATION, or other (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Nov. 6, 1968		Fairview Cemetery		Jersey City Bergen New Jersey			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Tyson Wheeler Funeral Home		1331 Rockville Pk. Rockville, Md.		DATE NOV 6 1968		<u>Charles Judge</u>			



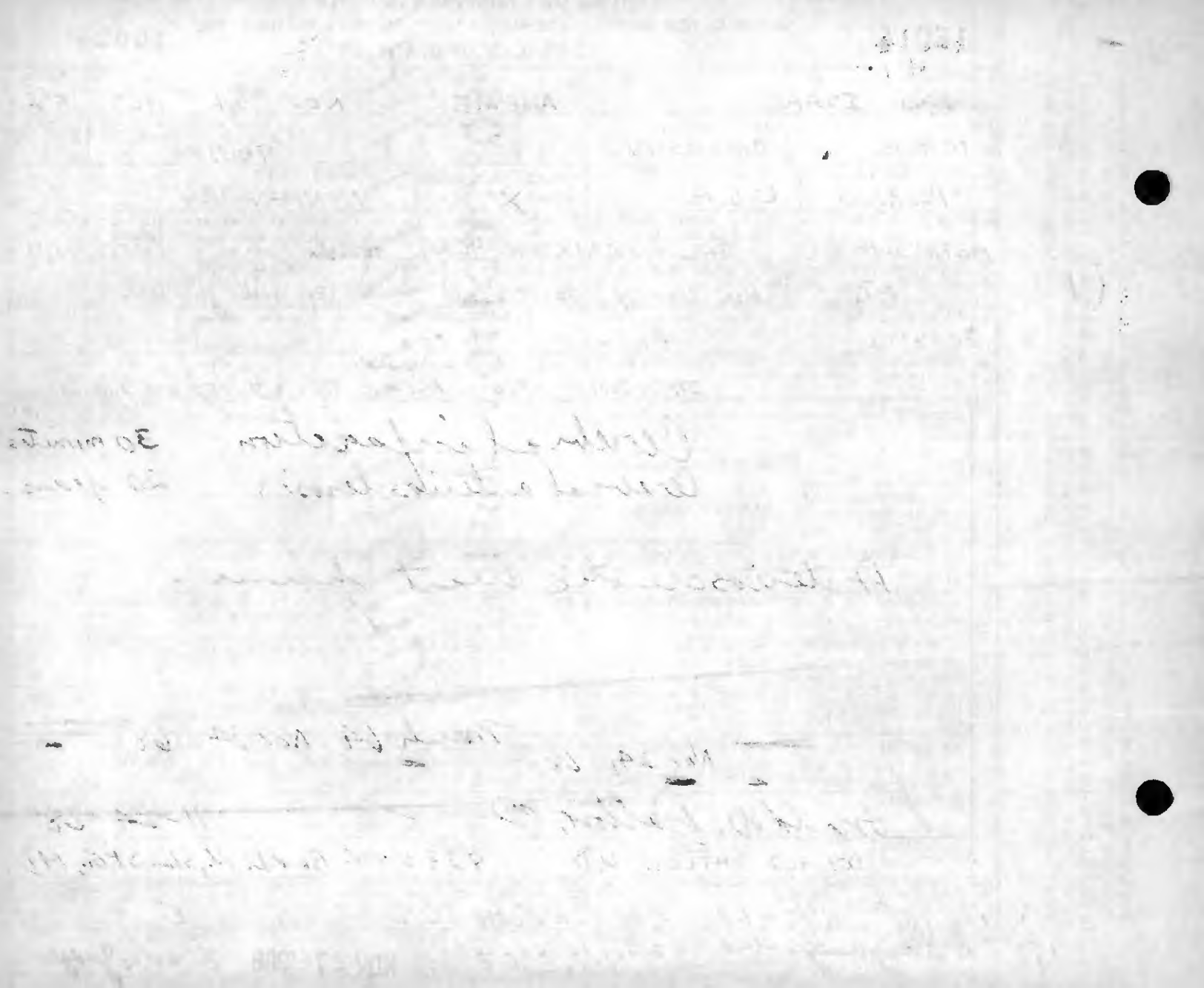
NAME	ADDRESS	CITY	STATE	ZIP
John Doe	123 Main St	New York	NY	10001
Jane Smith	456 Elm St	Los Angeles	CA	90001
Bob Johnson	789 Oak St	Chicago	IL	60601
Alice Brown	101 Pine St	San Francisco	CA	94101
Charlie White	202 Cedar St	Seattle	WA	98101
Diana Green	303 Birch St	Portland	OR	97201
Frank Black	404 Spruce St	Denver	CO	80201
Grace Hall	505 Willow St	Phoenix	AZ	85001
Henry King	606 Ash St	San Diego	CA	92101
Ivy Lee	707 Hickory St	San Jose	CA	95101
Jack Miller	808 Maple St	San Antonio	TX	78201
Karen Wilson	909 Poplar St	San Luis Obispo	CA	93401
Leo Taylor	1010 Sycamore St	San Bernardino	CA	92401
Mary Evans	1111 Walnut St	San Francisco	CA	94101
Nathan Adams	1212 Chestnut St	San Francisco	CA	94101
Olivia Baker	1313 Elm St	San Francisco	CA	94101
Peter Clark	1414 Oak St	San Francisco	CA	94101
Quinn Lewis	1515 Pine St	San Francisco	CA	94101
Rachel Hall	1616 Cedar St	San Francisco	CA	94101
Samuel King	1717 Birch St	San Francisco	CA	94101
Tina Lee	1818 Spruce St	San Francisco	CA	94101
Victor Miller	1919 Maple St	San Francisco	CA	94101
Wendy Wilson	2020 Poplar St	San Francisco	CA	94101
Xavier Taylor	2121 Sycamore St	San Francisco	CA	94101
Yara Evans	2222 Walnut St	San Francisco	CA	94101
Zoe Adams	2323 Chestnut St	San Francisco	CA	94101

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VR 115 (4)
30M REV. 11/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type and print) Rev. ISAAC			First Middle Last ANEMER			2a. DATE OF DEATH Month Day Year NOV 24 1968		2b. HOUR 5⁰⁰ A M	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH ?		6. AGE (In years last birthday) 96(2) YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country) POLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTEGOMERY Md.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GROSVENOR NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Rev.		12b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY MONTEGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 806 Whittington Terr.	
14. FATHER'S NAME First Middle Last Gedalia Anemer			15. MOTHER'S MAIDEN NAME First Middle Last Masha						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 271-34-8051 A		17. INFORMANT GRANDSON Address RABBI G. ANEMER 806 Whittington Terr, Silver Spring				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.9 Cerebral infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis 20 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 332x Arteriosclerotic heart disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDINGS, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from March 1964 to Nov 24, 1968 , that (I) (we) last saw the deceased alive on Nov 24, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (didn't) view the body after death.									
22b. SIGNATURE Donald W. Datlow, MD				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11-24-68	
22d. PHYSICIAN'S NAME (Type) DONALD DATLOW, MD				22e. ADDRESS 823 UNIV. BLVD. W, SIL SPRG, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/24/68		23c. NAME OF CEMETERY OR CREMATORY Mat-Cap Hebrew Cem.		23d. LOCATION (City or Town) (County) (State) Wash. D.C.			
24. FUNERAL DIRECTOR G. Wargansky & Sons				ADDRESS 3501-14 2nd St NW Wash D.C.		25a. RECD BY REGISTRAR DATE NOV 27 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

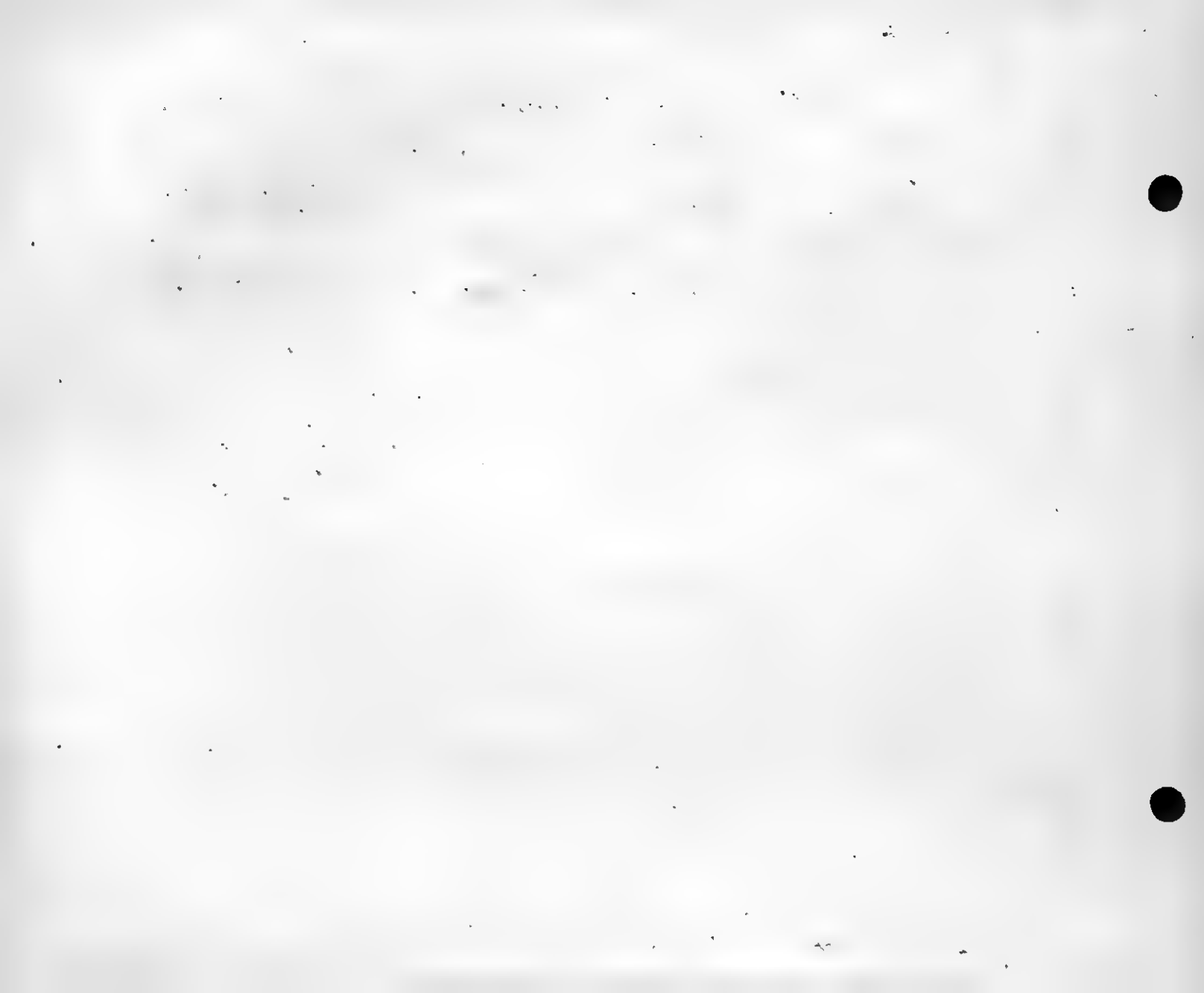
16015

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16029

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) JOHN J ANZELONE			2a. DATE OF DEATH 11 Month 22 Day 68 Year			2b. HOUR 12 50 P M	
3 SEX Male		4. RACE White		5. DATE OF BIRTH 1/7/24		6. AGE (In years lost birthday) 44 YRS.	
7a. BIRTHPLACE (State or foreign country) PENN.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.		12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) Art Display Manager		12b. KIND OF BUSINESS OR INDUSTRY Sears & Roebuck	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution, residence before admission). STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 10 111 51st AVE		14. FATHER'S NAME First James Middle Anzelone Last Anzelone		15. MOTHER'S MAIDEN NAME First Josephine Middle Pavalli Last Pavalli		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	
16b. SOCIAL SECURITY NO 204-16-5352		17. INFORMANT Mrs. Anne M. Anzelone		Address College Pk., Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon with metastases DUE TO, OR AS A CONSEQUENCE OF (b) Pelvic + intra-peritoneal rotation DUE TO, OR AS A CONSEQUENCE OF (c) 	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from 21 Nov , 19 68 , to 22 Nov , 19 68 , that (I) (we) last saw the deceased alive on 21 Nov , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE Ira N Brecher MD		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/22/68	
22d. PHYSICIAN'S NAME (Type) IRA N BRECHER MD		22e. ADDRESS 800 Pershing Dr., Silver Spring, Md		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE 11-25-1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Monta. Md.		24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.	
24a. ADDRESS 8434 Ga. Avenue		24b. REC'D BY REGISTRAR Charles Judge		24c. DATE NOV 27 1968		24d. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16015

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16015

1 DECEASED NAME (Type or Print) Fred Armstrong			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year 11-13 19 68 9A		
3 SEX Male	4 RACE Cauc	5 DATE OF BIRTH 1-4-1913	6 AGE (in years last birthday) 55 YRS	7 UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0	2c. DATE PRONOUNCED DEAD 11-13 Year 1968 9A
7a BIRTHPLACE (State or foreign country) ROMANIA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Montgomery		10 CITY OR TOWN OF DEATH Silver Spring			
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3528 GREENLEY ST.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SALESMAN		12b KIND OF BUSINESS OR INDUSTRY Men's Clothing	
13a U.S.A. RESIDENCE (Where deceased lived if institution admission) STATE MD		13b COUNTY Montgomery		13c CITY OR TOWN S.S.	
14 FATHER'S NAME First EMANUEL Middle GOLDSTEIN Last ROSE		15 MOTHER'S MAIDEN NAME First ROSE Middle ? Last ?		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16b SOCIAL SECURITY NO UNKNOWN		17 INFORMANT SHIRLEY K. ARMSTRONG		ADDRESS Same As 13	
18 CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF Coronary Artery Heart Disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 11-15-1968 HOUR A.M. 19 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No 3528 City or Town Silver Spring County Montgomery State MD	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Belden R. Keap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED Nov. 13, 1968	
EXAMINER'S NAME (Type) BELDEN R. KEAP M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (City, State, and county) Falls Church VA	
23a BURIAL CREMATION REMOVAL (Specify) BURIAL		23b DATE 11-15-1968		23c NAME OF CEMETERY OR CREMATORY WATKINS MEM. PARK	
24 FUNERAL DIRECTOR GOLDBERG FUNERAL HOME		ADDRESS 4217 9TH ST. N.W.		25a REC'D BY REG. STRAR NOV 18 1968	
				25b REGISTRAR'S SIGNATURE James J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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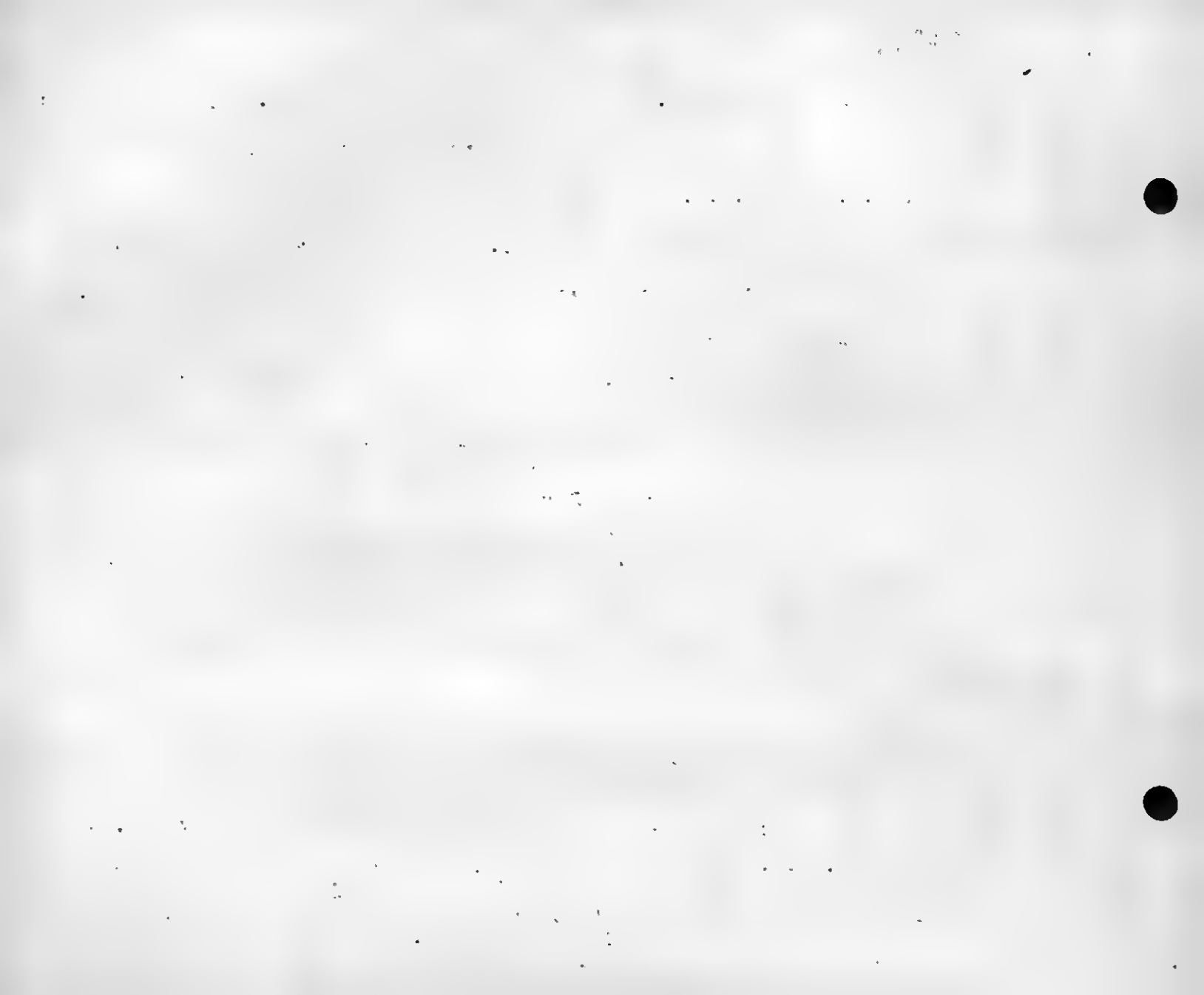
16017

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16017

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Francis I. Ashe			2a. DATE OF DEATH Nov. Month 30 Day 1968 Year		2b. HOUR 1:30 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH March 25, 1898		6. AGE (In years last birthday) 70 YRS.	7. UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Washington D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Gaithersburg	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 17-10 Longdraft Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sheet Metal Worker		12b. KIND OF BUSINESS OR INDUSTRY Heating
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 1201 Longdraft Rd.	
14. FATHER'S NAME First Middle Last Alougius Ashe		15. MOTHER'S MAIDEN NAME First Middle Last Cornelia Fowler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 216 07 4930	17. INFORMANT Address Mrs. Alberta Ashe (wife) Same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 41- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Coronary Insufficiency</u> (b) DUE TO, OR AS A CONSEQUENCE OF <u>Hypertension</u> (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>2 yrs</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hx. 1</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1966</u> , to <u>11-30, 1968</u> , that (I) (we) last saw the deceased alive on <u>11-22, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>F. J. Brochart</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>11-30-68</u>		
22d. PHYSICIAN'S NAME (Type) Dr. F.J. Brochart		22e. ADDRESS 11 Hutton St. Gaithersburg, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec 3, 68	23c. NAME OF CEMETERY OR CREMATORY Gate Of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring Montg. Md.	
24. FUNERAL DIRECTOR Tyson Heeler Funeral Home Rockville, Md.		ADDRESS Rockville		25a. REC'D BY REGISTRAR DATE DEC 5 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

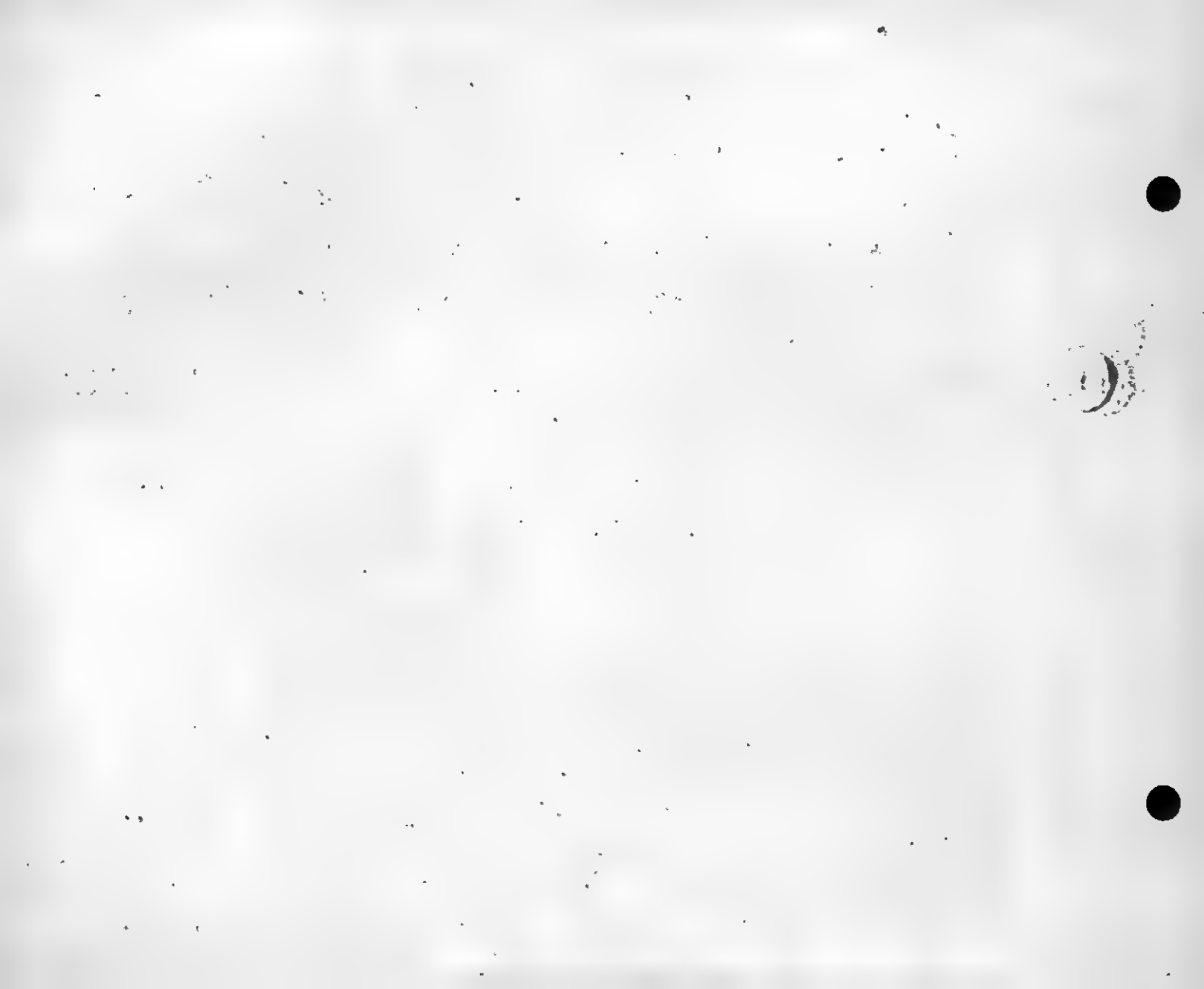


1

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) <i>Frances ATCHLEY</i>		Middle <i>Frances</i>		Last <i>ATCHLEY</i>		2a. DATE OF DEATH Month <i>11</i> Day <i>29</i> Year <i>1968</i>		2b. HOUR <i>PM</i>	
3 SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>10-25-1881</i>		6. AGE (In years Month Day) <i>87</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Kentucky</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>		Md	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>12508 Holldridge Rd.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>12508 Holldridge Rd.</i>	
14. FATHER'S NAME First <i>unknown</i> Middle <i>unknown</i> Last <i>unknown</i>				15. MOTHER'S MAIDEN NAME First <i>unknown</i> Middle <i>unknown</i> Last <i>unknown</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, np, or unknown) <i>no</i>		16b. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Mrs. Clarence Moore</i> Address <i>12508 Holldridge Rd. Silver Spring, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Generalized Metastatic</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinomatosis due to Cancer</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>of the Esophagus</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>15.</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>May, 1966</i> , to <i>Nov. 29, 1968</i> , that (I) (we) last saw the deceased alive on <i>11/29/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (diagnose) view the body after death.									
22b. SIGNATURE <i>Gelden R. Keap</i>		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>GOLDEN R. KEAP, M.D. WHEATON, MARYLAND</i>		22e. DATE SIGNED <i>11/29/1968</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>12/2/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Monte Vista Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Johnson City, Tenn.</i>			
24. FUNERAL DIRECTOR <i>J.W. Lee</i>		24b. ADDRESS <i>8434 Georgia Ave.</i>		25a. REC'D BY REGISTRAR <i>DEC 5 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
Warner E. Pumphrey, Inc. Silver Spring, Md.									





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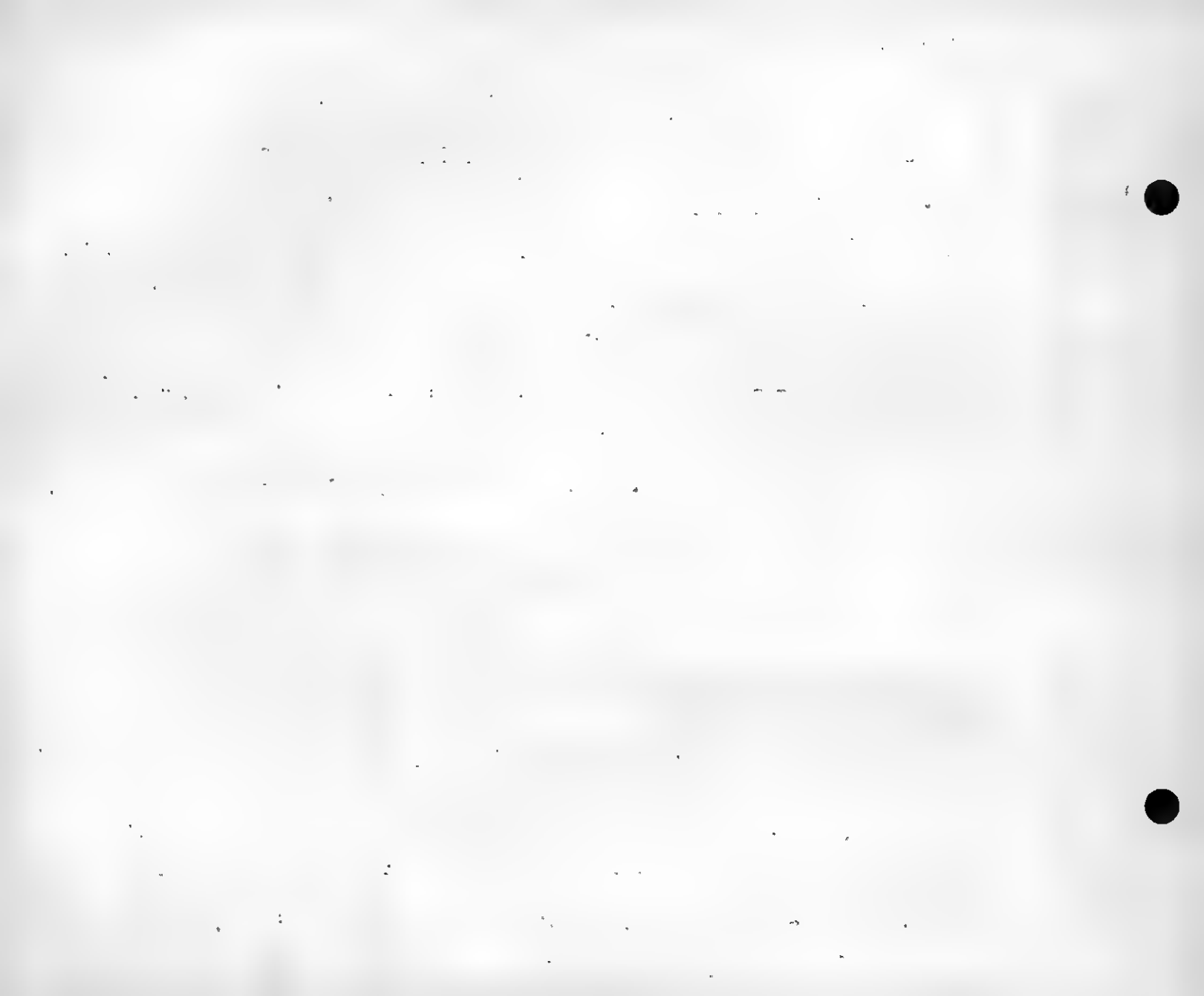
VR 100-10
30M RE-1768

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16020

16034

1. DECEASED NAME (Type or print) Mango First Joan Middle Baltrotsky Last			2a. DATE OF DEATH Nov Month 1 Day 1968 Year		2b. HOUR SA M
3. SEX Female	4. RACE White	5. DATE OF BIRTH Dec. 31, 1933		6. AGE (In years last birthday) 34 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Wash. D. C.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Sil. Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) 1801 Arcola Avenue		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Spr.	13d. INS. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1801 Arcola Avenue
14. FATHER'S NAME First John Middle Rathall Last		15. MOTHER'S MAIDEN NAME First Margaret Middle Hei Last ett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO yes	17. INFORMANT Address Maryland Martin Baltrotsky 1801 Arcola Ave. Sil. Spr.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 114x (b) Adenocarcinoma of Breast DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 22 mos.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from April , 19 67 , to Nov 1 , 19 68 , that (I) (we) lost saw the deceased alive on 10/30 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE G. Leonard Gold		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/1/68	
22d. PHYSICIAN'S NAME (Type) G. Leonard Gold, M.D.		22e. ADDRESS Gr. Ave. & Brent Cl. H. S.S., Md.			
23a. BURIAL CREMATION REMOVAL (Specify) burial	23b. DATE 11-11-1968	23c. NAME OF CEMETERY OR CREMATORY St. Vincent Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland	
24. FUNERAL DIRECTOR M. Andrew Duwall		24a. ADDRESS 1100 E. 10th St. Baltimore, Md.		24b. REC'D BY REGISTRAR NOV 7 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pen in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI MATED			Month Day Year		
DOUGLAS BARDEN KELTON			KELTON DOUGLAS BARDEN			11-23			68		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER MONTHS	YEAR	IF UNDER 24 HRS	HOURS	MIN	2c. DATE PRONOUNCED DEAD	Month	Day
Male	White	9-21-1950	18						11-23	68	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			2d. HOUR		
Wash., D. C.		USA				Montgomery			530		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			12819 New Hampshire Ave SS			Asst. Bricklayer			Construction		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Montgomery			Silver Spring			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER					
Claude E. Barden			Willie M. Kirk			711 Tanley Road					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			Yes			Mr. Claude E. Barden			Sil. Spr., Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot wound in head accidentally											
DUE TO, OR AS A CONSEQUENCE OF (b) self-inflicted with exsanguination.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
911											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				5:10 P.M. 11-23 1968				Deceased shot self in head while playing Russian Roulette			
21d. INJURY OCCURRED WHERE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or RFD No City or Town County State			
				Home				Silver Spring Montg. Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER							
BELODEN R. KEAP				DEPUTY MEDICAL EXAMINER							
				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial				11-26-1968		Colesville Cemetery		Montgomery, Maryland			
24. FUNERAL DIRECTOR				ADDRESS				REC'D BY REGISTRAR		25. REGISTRAR'S SIGNATURE	
M. Andrew Duwall				Silver Spr. Md.				NOV 29 1968		Charles Judge	
Warner E. Pumphrey, Inc. 8434 Georgia Avenue											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no case within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

160228

16036

1 DECEASED-NAME (Type or print) MARY ELIZABETH BARRETT			2a. DATE OF DEATH Month November Day 19 Year 1968			2b. HOUR 2:40 P.M.				
3 SEX Female		4 RACE White		5. DATE OF BIRTH October 4 - 1885		6. AGE (In years last birthday) 83 YRS.		7 UNDER 1 YEAR MONTHS 1 DAYS 10 HOURS 40 M.N.		
7a. BIRTHPLACE (State or foreign country) WASHINGTON DC		7b. CITIZEN OF WHAT COUNTRY? USA.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY Md.				
10. CITY OR TOWN OF DEATH OLNEY		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Brooke Grove Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerical			12b. KIND OF BUSINESS OR INDUSTRY Railroad			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE WASHINGTON D.C.		13b. COUNTY WASH D.C.		13c. CITY OR TOWN WASH D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3502 36th ST. N.W.		
14 FATHER'S NAME First JAMES Middle BARRETT Last BARRETT			15 MOTHER'S MAIDEN NAME First SUSAN Middle - Last Rabe							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 718-105-461		17 INFORMANT Alberta CONNER - 3502-36th ST. N.W.				Address WASH. DC 20016	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL APOPLEXY 4129 DUE TO, OR AS A CONSEQUENCE OF CEREBRAL SCLEROSIS Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last GENERAL ASCVD (b) TERMINAL (c) YRS YRS									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) SENILITY - ORGANIC BRAIN SYNDROME										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 4 Month 11 Day 19 Year 1968 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION (Street or R.F.D. No. City or Town County State)						
22a. I certify that (I) (this hospital) attended the deceased from 4/17 , 19 66 to 11/19 , 19 68 , that (I) (we) last saw the deceased alive on 11/18 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Donald R. Lewis M.D.				22c. DATE SIGNED 11/19/68		22d. PHYSICIAN'S NAME (Type) DONALD R. LEWIS				
22e. ADDRESS 700 CLOVERLY: SIL SPR. MD.										
23a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL		23b. DATE 11-22-1968		23c. NAME OF CEMETERY OR CREMATORY MOUNT OLIVET CEMETERY WASHINGTON, D.C.		23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C.				
24. FUNERAL DIRECTOR JOSEPH GAULIER'S SONS INC., 5130 WISG. AVE. N.W., WASH. D.C., 20016				25a. REC'D BY REGISTRAR NOV 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <i>Dorethy</i>			First <i>L.</i> Middle <i>BARUCH</i> Last			2a. DATE OF DEATH Month <i>11</i> Day <i>12</i> Year <i>68</i>			2b. HOUR <i>10³⁸</i> AM
3 SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>12-26-18</i>		6. AGE (In years lost birthday) <i>49</i> YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Chester, Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution) Res dence before admission) STATE <i>md.</i> COUNTY <i>Bethesda</i>		13b. CITY OR TOWN <i>Bethesda</i>		13c. INSIDE CITY, MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4520 Linden Ave.</i>			
14. FATHER'S NAME First <i>Charles A.</i> Middle <i>McNaney</i> Last				15. MOTHER'S MAIDEN NAME First <i>Anna E.</i> Middle <i>Sutton</i> Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>577-10-5443</i>		17. INFORMANT <i>Husband</i>		Address <i>Same as Item 13.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage.</i> <i>4307</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Ruptured aneurysm.</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>330X NONE</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>11-4</i> , 19 <i>68</i> , to <i>11-12</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>11-12</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Marvin C. Korengold</i> MD				22c. DATE SIGNED <i>11-12-68</i>		22d. PHYSICIAN'S NAME (Type) <i>MARVIN C. KORENGOLD</i>			
22e. ADDRESS <i>2141 K St. NW. Wash D.C.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>11-16-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>			
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR <i>DA NOV 20 1968</i>		25b. REGISTRAR'S SIGNATURE <i>W. Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 1511
3044 REV 1-64

16024

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16033

CERTIFICATE OF DEATH

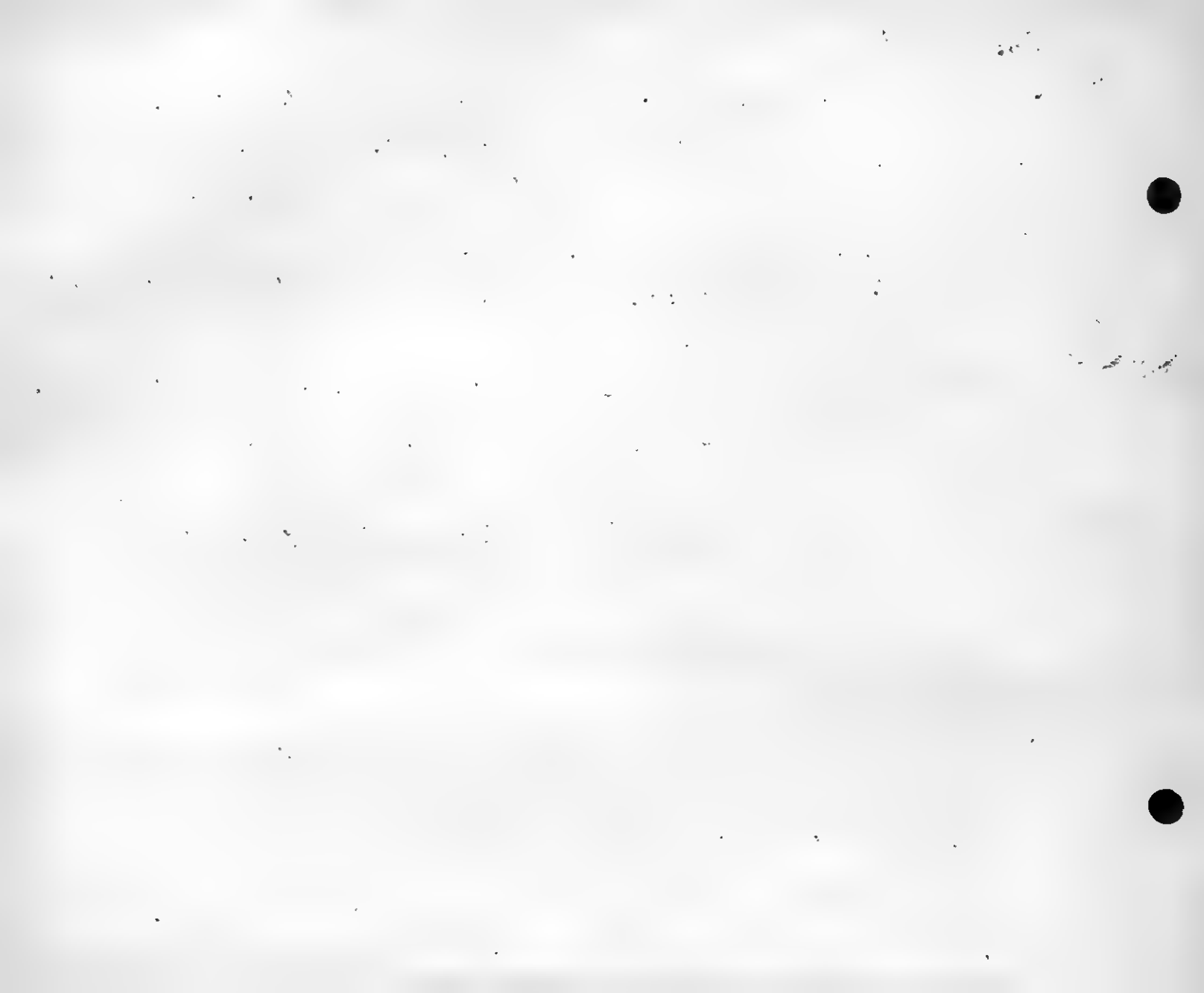
1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b HOUR 35 8 P M			
3 SEX Female		4 RACE white		5. DATE OF BIRTH 1/8/89		6 AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS - -		IF UNDER 24 HRS. HOURS MIN - -	
7a BIRTHPLACE (State or foreign country) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery County Md.					
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SAGES RANC Convalescent		12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY -					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Bethesda		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 8114 Old Georgetown Rd.			
14 FATHER'S NAME John		First	Middle	Last	15 MOTHER'S MAIDEN NAME Rebecca		First	Middle	Last Scull		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) unknown		(If yes give war or dates of service) -		16b SOCIAL SECURITY NO. 216-40-5687		17 INFORMANT Mrs. Martha J. McInerney 601 Hurdinglee Rd. Sil. Sp. Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> 4367 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE PERIOD BETWEEN ONSET AND DEATH 24 HRS 5 WKS 10 YRS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from 10/17, 1968, to 11/25, 1968, that (I) (we) last saw the deceased alive on 11/16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE Ronald W. Barr		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 11/25/68					
22d. PHYSICIAN'S NAME (Type) RONALD W. BARR, M.D.		22e ADDRESS 18401 OLD GEORGETOWN RD BETHESDA, MD.									
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE 11-24-68		23c NAME OF CEMETERY OR CREMATORY Landon Hill Cemetery		23d LOCATION (City or Town)		(County)		(State)	
24 FUNERAL DIRECTOR Francis Collins		ADDRESS 500 Univ. Blvd.		25a REC'D BY REGISTRAR DEC 2 1968		25b REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Clear by medical examiner

16025										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16031																																							
1 DECEASED-NAME (Type or print) First FRANK Middle M. Last BENEDETTI										2a. DATE OF DEATH 11 Month 25 Day 68 Year										2b. HOUR																																							
3. SEX Male										4 RACE White										5 DATE OF BIRTH 12/29/97										6. AGE (in years lost birthday) 70 YRS. 10 MONTHS 26 DAYS										IF UNDER 1 YEAR 10 MONTHS 26 DAYS										IF UNDER 24 HRS 10 MONTHS 26 DAYS									
7a. BIRTHPLACE (State or foreign country) Italy										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Montgomery										Md.																			
10. CITY OR TOWN OF DEATH Silver Spring										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Barber										12b. KIND OF BUSINESS OR INDUSTRY																													
13a. U.S.A. RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.										13b. COUNTY Montgomery										13c. CITY OR TOWN Silver Spring										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 4301 Robert Court																			
14. FATHER'S NAME First Adelpho Middle Benedetti Last										15. MOTHER'S MAIDEN NAME First Middle Last																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go, or (unknown) No										16b. SOCIAL SECURITY NO. 578-27-7766										17 INFORMANT Sam V. Benedetti - son										Address 4112 Howard St., Md.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
4120										IMMEDIATE CAUSE (a) Respiratory arrest										minutes																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										DUE TO, OR AS A CONSEQUENCE OF (b) Intercranial hemorrhage										12 hr																																							
										DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension & S. Cardiovascular disease										Years																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										44																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from July, 1958, to Nov 25, 1968, that (I) (we) last saw the deceased alive on Nov 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE Richard P. Delaney										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED																																							
22d. PHYSICIAN'S NAME (Type) Richard P. Delaney										22e. ADDRESS 4723 Harvard St., Silver Spring, Md.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE 11/27/68										23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery										23d. LOCATION (City or Town) (County) (State) Washington, D.C.																													
24. FUNERAL DIRECTOR Wheeler Funeral Home										ADDRESS 1331 Rock Pike Rockville, Maryland										25a. REC'D BY REGISTRAR Charles Judge										25b. REGISTRAR'S SIGNATURE Charles Judge																													
DATE NOV 27 1968																																																											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16026

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16026

1. DECEASED-NAME (Type or print) VIVIAN ALEXIA BERESFORD			2a. DATE OF DEATH Month Nov Day 18 Year '68		2b. HOUR 11:30 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH 10-20 1903		6. AGE (In years lost birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Minnesota	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 10412 Montrose Ave	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY At Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY (LIMITS)? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 10412 Montrose Ave	
14. FATHER'S NAME First Middle Last Edward Brand		15. MOTHER'S MAIDEN NAME First Middle Last Mary Elizabeth Hill			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 470-07-0014	17. INFORMANT Address 10412 Montrose Ave Bethesda, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4147					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 42-1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
2. d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1964 , 19____, to Nov 19, 1968 , that (I) (we) last saw the deceased alive on Nov 25, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert T. Thibodeau		DEGREE MD		22c. DATE SIGNED Nov 19-68	
22d. PHYSICIAN'S NAME (Type) ROBERT T. THIBODEAU		22e. ADDRESS ROCKVILLE MD 20852			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 11-21-68	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland Pr. Geo Md	
24. FUNERAL DIRECTOR Robert A Pumphrey		ADDRESS 7557 Wisconsin Ave Bethesda, Md.		25a. REC'D BY REGISTRAR DNV 6 1 1968	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATE ON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

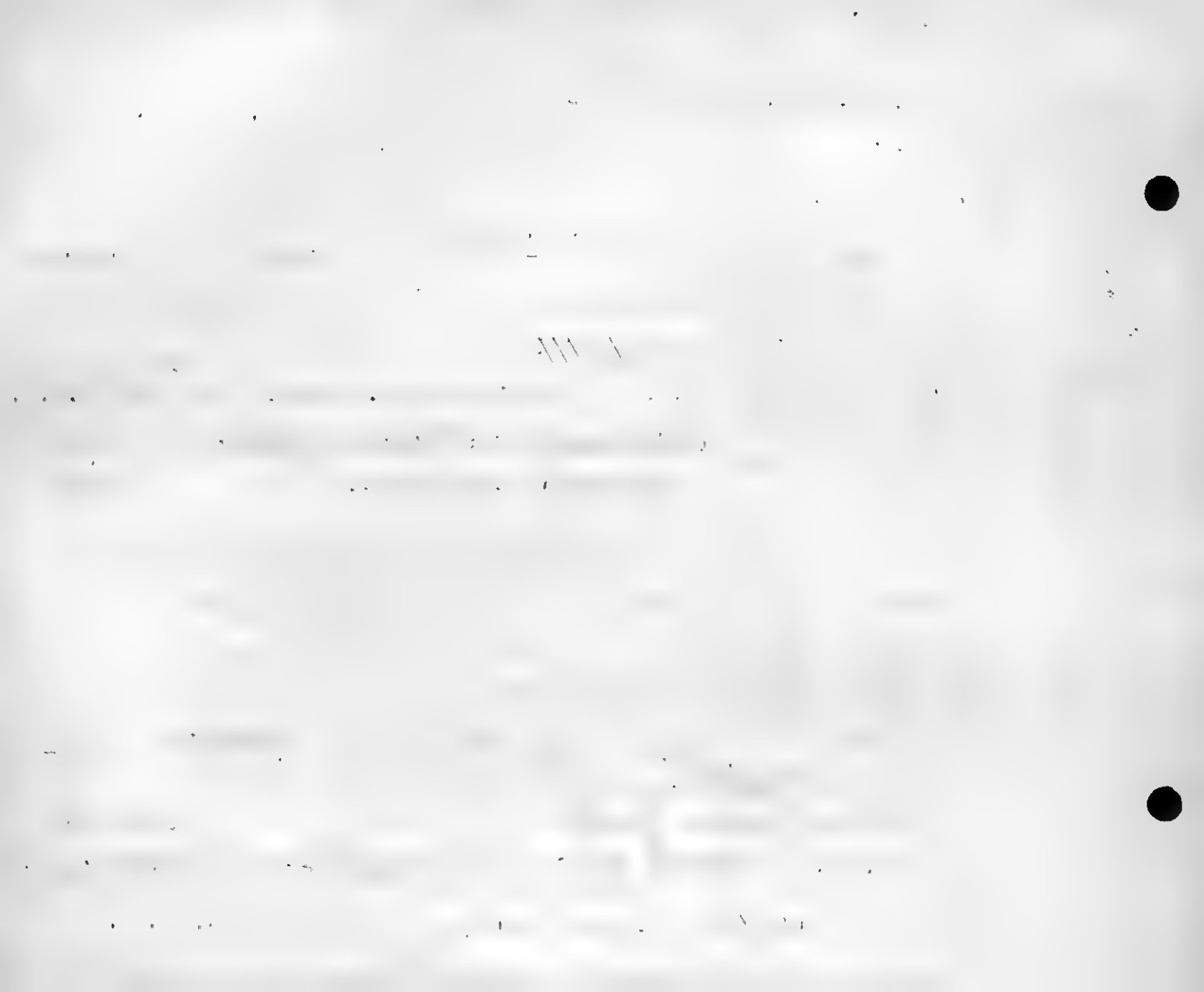
16027

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16041

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Mabel R. Blackman			2a. DATE OF DEATH Month November Day 19 Year 1968			2b. HOUR 2:15 PM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH March 5 - 1876		6. AGE (in years lost birthday) 92 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (State or foreign country) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Kensington MD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Hall 10231 Carroll Rd - Sancti Spiritus		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY XXXXXXXXXX			
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE MD COUNTY Montgomery		13b. CITY OR TOWN Washington DC		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 1346 Park Rd NW			
14. FATHER'S NAME First Christopher Middle Sherwood Last Palmer			15. MOTHER'S MAIDEN NAME First Margaret Middle Palmer Last Palmer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. 575-10-7749		17. INFORMANT Elizabeth B. Lehman		Address Washington DC 1346 Park Rd. N.W.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease & failure DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 10 yrs.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1955 , 19____, to present , 19____, that (I) (we) last saw the deceased alive on 23 Oct 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles E. Keegan Jr MD		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 19 Nov 68			
22d. PHYSICIAN'S NAME (Type) CHAS. E. KEEGAN JR MD		22e. ADDRESS 3152 Benton St NW. Wash. DC 20007							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/22/68		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C.			
24. FUNERAL DIRECTOR THE S.H. HINES CO		ADDRESS 2901-14TH ST. N.W. WASH. DC		25a. REC'D BY REGISTRAR NOV 21 1968		25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card body of this certificate and file it in the records of the State Dept. of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.

1

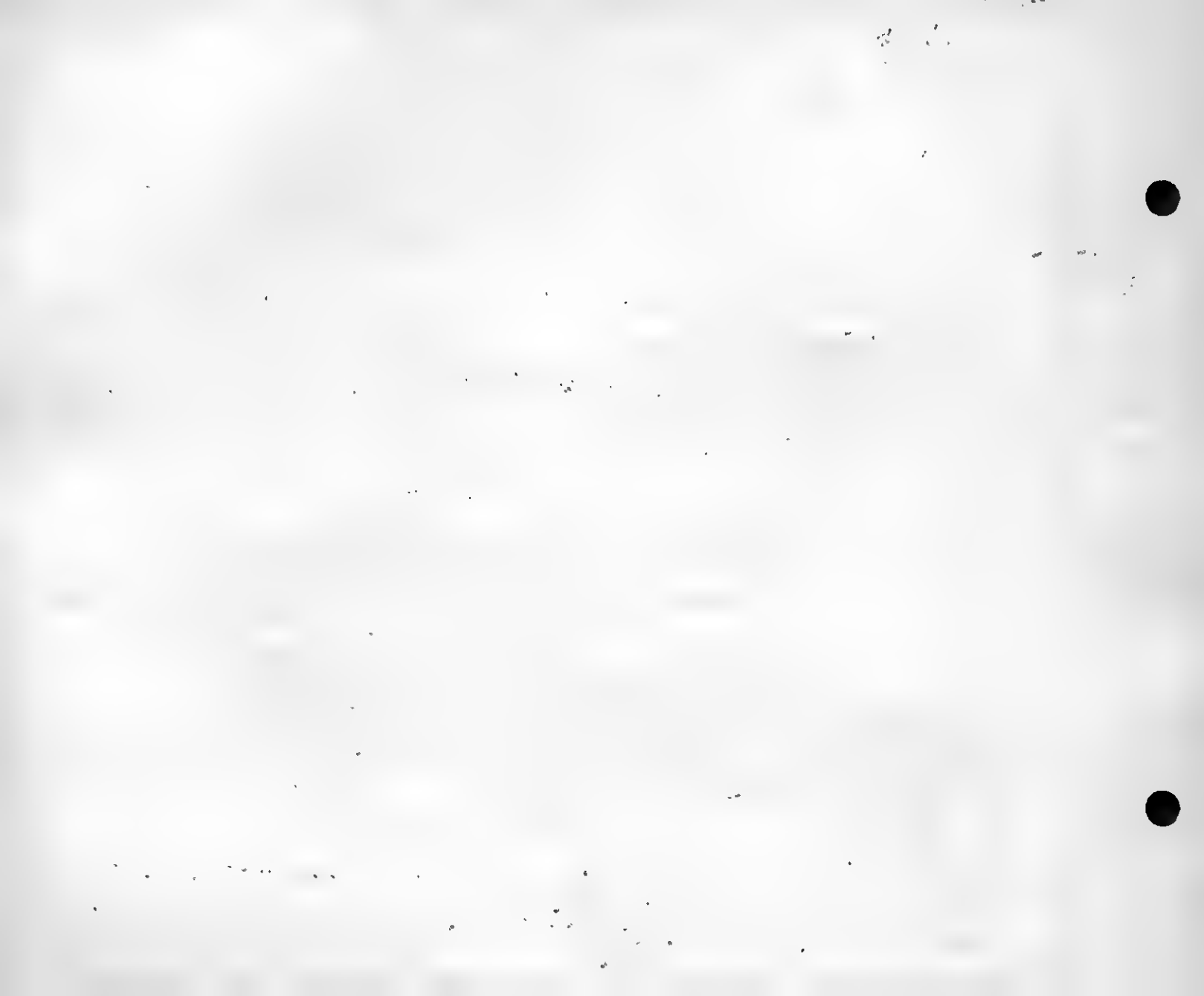
16028

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16040

1. DECEASED NAME (Type or print) DAVID		First Middle Last		2a. DATE OF DEATH Month 11 Day 3 Year 68		2b. HOUR 8:45 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 3/10/83		6. AGE (in years lost birthday) 85 YRS	
7a. BIRTHPLACE (State or foreign country) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY COUNTY Md	
1d. CITY OR TOWN OF DEATH SILVER SPRING MD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1900 LYTTONSVILLE RD.		14. FATHER'S NAME First MORDECAI Middle BLOOM Last		15. MOTHER'S MAIDEN NAME First YACHYA Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 578-48-9418		17. INFORMANT Mrs. Robert Langert		Address 70413 Trumpet Rd Adelphi MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CA of Lung DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 9-27 , 19 68 , to 11-3 , 19 68 , that (I) (we) lost saw the deceased alive on 11-2 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G.B. Cushman M.D.				22c. DATE SIGNED 11-3-68			
22d. PHYSICIAN'S NAME (Type) GILBERT B CUSHNER				22e. ADDRESS 11161 NEW HAMPSHIRE AVE SILVER SPRING MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11/5/68		23c. NAME OF CEMETERY OR CREMATORY Montefiore Cemetery		23d. LOCATION (City or Town) (County) (State) New York N.Y.	
24. FUNERAL DIRECTOR B. Dargatzis & Sons 3501 14th St N.W. Wash. D.C.				25a. REC'D BY REGISTRAR NOV 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>16029</div> <div>16043</div>									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR	
Mary			E Boardley			<input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> 11 9 1968		7 1/2 M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 24 HRS	8 MONTHS	9 DAYS	10 HOURS	11 MIN	12c DATE PRONOUNCED DEAD
F	Negro	8/1/94	74 YRS.						2d HOUR 11 9 1968 9 1/2 M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		9 COUNTY OF DEATH			
Glenwood, Md		U.S.A		<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		Montgomery Co		Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Bethesda		Gravesend Home Mrs. Home		Cook					
13a USUAL RESIDENCE (Where deceased lived, if institution)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Maryland		Howard Co		Dayton		<input type="checkbox"/> YES <input type="checkbox"/> NO		Howard Rd	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
THOMAS BUTLER			EMMA HOPKINS						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT		ADDRESS	
			217-40-0316T			Emma C. Stalters		13514 Oriental St. Rockville, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis.</u>									17 days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio Sclerosis.</u>									years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
332X Obesity									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
							<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
			P.M. 19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b DATE SIGNED			
John S. Ball			<input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER			Nov 9, 1968			
EXAMINER'S NAME (Type)			ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
BURIAL		11-14-68		Bushy PARK Cem.		Cocksville, Howard Md			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Robert L. Snowden			Rockville, Md.			DATE NOV 18 1968 Charles Judge			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16030

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10001

1. DECEASED-NAME (Type or print) First Middle Last LILLIE MAE BOOZE			2a. DATE OF DEATH Month Day Year 11- 4- 68		2b. HOUR 3A M
3. SEX FEMALE	4. RACE NEGRO	5. DATE OF BIRTH 1-1-1883		6. AGE (In years lost birthday) 85 YRS	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md
10. CITY OR TOWN OF DEATH COLESVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BELMONT NURSING HOME		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) DOMESTIC	
12b. KIND OF BUSINESS OR INDUSTRY NONE					
13a. JSSA. RESIDENCE (Where deceased admission) STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BROOKVILLE	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 19919 ZION ROAD			
14. FATHER'S NAME First Middle Last HENSON JOHNSON		15. MOTHER'S MAIDEN NAME First Middle Last HENRIETTA DORSEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 212-20-1552		17. INFORMANT NURSING HOME RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 6 MO. 4124 DUE TO, OR AS A CONSEQUENCE OF CORONARY ARTERY SCLEROSIS 4 YRS (b) DUE TO, OR AS A CONSEQUENCE OF ARTERIOSELEPTIC C.V.D. 4 YRS (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHRONIC NEPHRITIS : ORGANIC BRAIN SYNDROME - SENILE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (1) (this hospital) attended the deceased from NOVEMBER 1964, to NOV 4, 1968, that (1) (we) last saw the deceased alive on OCT 14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Donald R. Lewis M.D.		DEGREE M.D.		22c. DATE SIGNED Nov 5, 68	
22d. PHYSICIAN'S NAME (Type) Donald R. Lewis, M.D.		22e. ADDRESS 700 Cloverly St. Sil. Spr. Md.			
23a. BURIAL, CREMATION, REMOVAL, (Specify) BURIAL		23b. DATE 11-8-68		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	
23d. LOCATION (City or Town) (County) (State) Mt. Zion montg Md.					
24. FUNERAL DIRECTOR ROBERT L. SNOWDEN		ADDRESS ROCKVILLE, MARYLAND		25a. REC'D BY REGISTRAR DATE NOV 12 1968	
		25b. REGISTRAR'S SIGNATURE Charles Judge			

16031

CERTIFICATE OF DEATH

1604

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

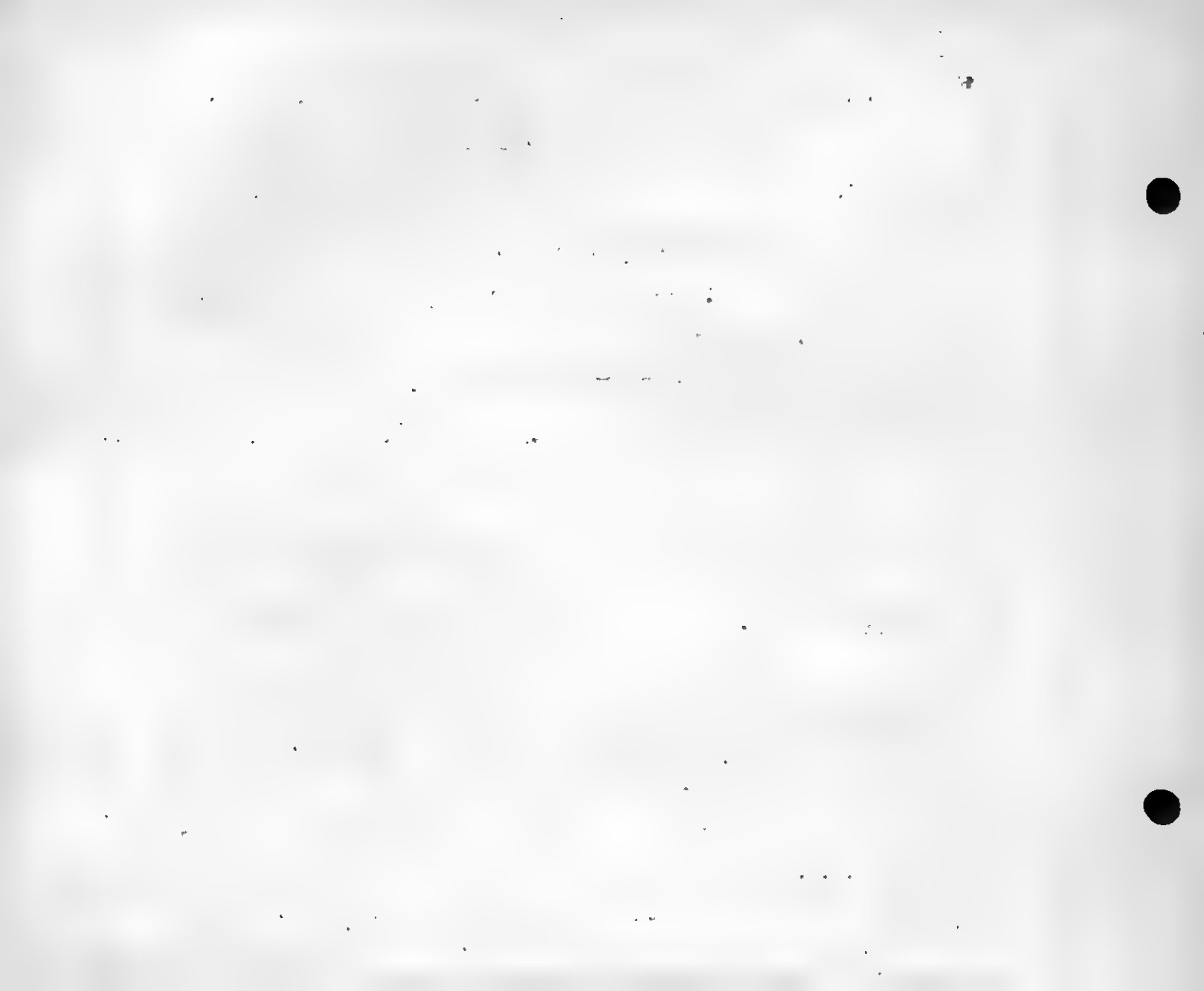
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1968</u>			2b. HOUR <u>P</u> <u>3:52</u>	
Victor			Stephan			Boretsky				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 17 August 1955			6. AGE (In years last birthday) 13 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia		13b. COUNTY Fairfax		13c. CITY OR TOWN Falls Church		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3006 Pine Spring Road		
14. FATHER'S NAME Michael			First	Middle	Last	15. MOTHER'S MAIDEN NAME Halyna			Neczyporuk	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. None		17. INFORMANT Bethesda, Maryland The Medical Records, The Clinical Center					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular and Respiratory Arrest</u> <u>1929</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Medulloblastoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic nodule to cervical spinal cord</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH <u>Immediate</u> <u>1 year</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
<u>Metastatic nodule to cervical spinal cord</u>										
19a. DATE OF OPERATION <u>10/22/68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Placement of Ommaya reservoir</u>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that <u>he</u> (this hospital) attended the deceased from <u>15 October, 1968</u> , to <u>8 Nov. 1968</u> , that <u>we</u> (we) last saw the deceased alive on <u>8 November 1968</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>we</u> (we) (did) (did not) view the body after death										
22b. SIGNATURE <u>Howard H. Kaufman MD</u>									22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) Howard H. Kaufman, MD.									22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL <u>Removal</u>		23b. DATE <u>11/10/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Andrews Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>So. Bound Brook, N.J.</u>			
24. FUNERAL DIRECTOR Falls Church Funeral Home, Virginia					25a. REC'D BY REGISTRAR DATE <u>NOV 14 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
16032																
16046																
CERTIFICATE OF DEATH																
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR					
Julia			Helen		Bourquardez		Nov.		Month 3 Day 68 Year		3:55 PM					
3 SEX			4 RACE			5. DATE OF BIRTH			6 AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Female			White			10-31-96			72 YRS.							
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH							
Illinois			USA						Montgomery					Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY							
Olney			Montgomery General Hospital									Retired				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER				
Maryland			Montgomery			Silver Spring						3312 Chiswick Court				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME													
First Middle Last			First Middle Last													
Alfred P. Bourquardez			Nora			Healy										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT										
No			127-38-5730			Hospital Records										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Anaplastic Reticulo-Endothelial Sarcoma</u>										1 month						
DUE TO, OR AS A CONSEQUENCE OF (b) <u>type undetermined</u>																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
11/1/68			Biopsy			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
			HOUR AM. Month Day Year P.M. 19													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from <u>11/1/68</u> , to <u>Nov 3 1968</u> , that (I) (we) last saw the deceased alive on <u>11/2/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE			22c. DATE SIGNED													
Ruth A. Yates M.D.			11/3/68													
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS													
Dr. R.A. Yates			OLNEY, MD.													
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)							
Burial			11-5-68			WOODLAWN CEMETERY			NEW YORK N.Y.							
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Francis Collins			500 University Blvd W.			NOV 6 1968			Charles Judge							

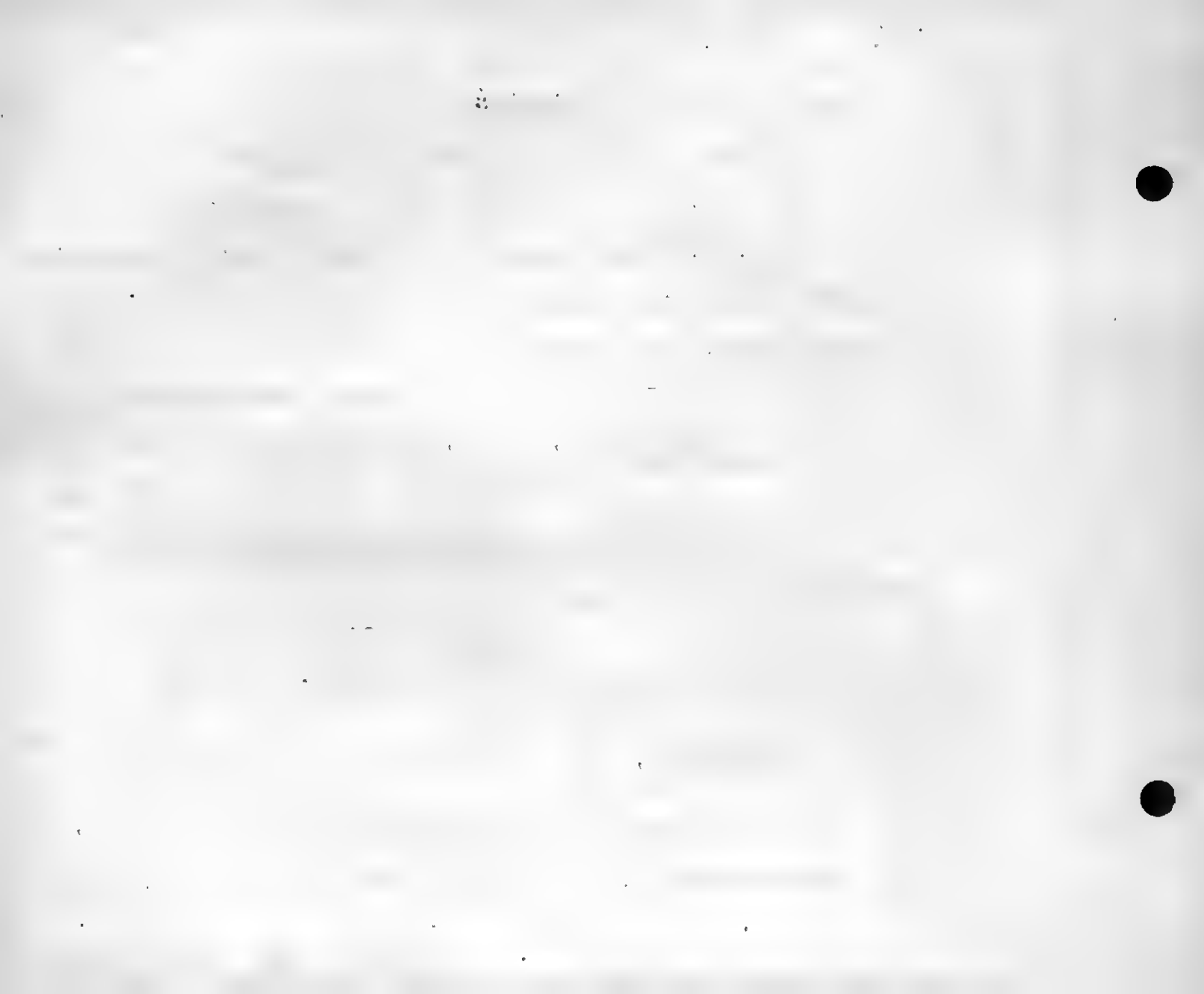


16033

MEDICAL CERTIFICATION

VR A15 (4)
30M REV 1/68

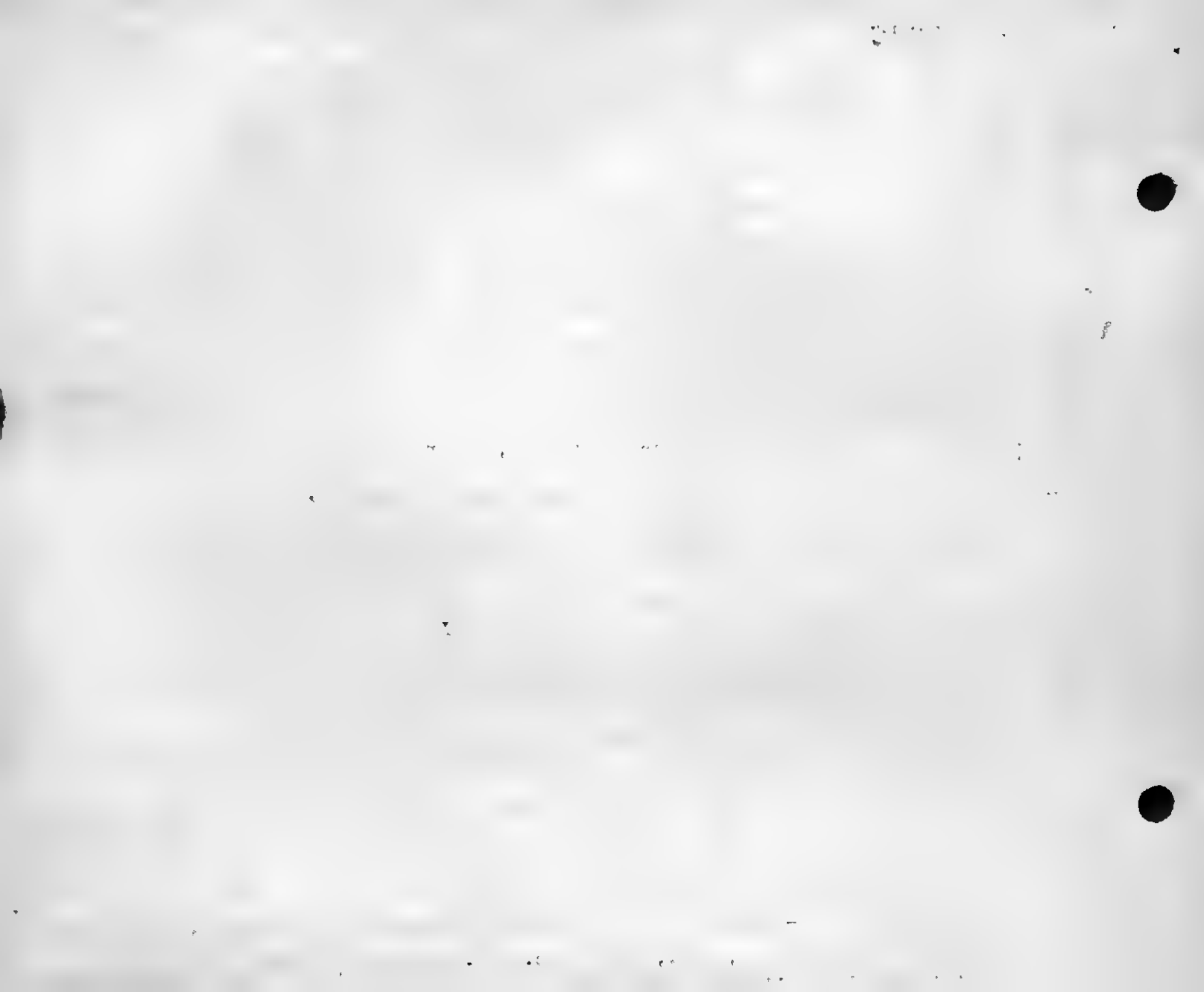
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16033 CERTIFICATE OF DEATH 16041											
1. DECEASED NAME (Type or print) First Middle Last Alton Parker Brandenburg						2a. DATE OF DEATH Month Day Year 11 7 68		2b. HOUR 9:00 A			
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 15, 1904		6. AGE (In years last birthday) YRS 64		IF UNDER 24 HRS MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.O.A. Montgomery General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Foreman-auto parts		12b. KIND OF BUSINESS OR INDUSTRY Automobile					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5 Baker Ave.			
14. FATHER'S NAME First Middle Last William Bromwell Brandenburg				15. MOTHER'S MAIDEN NAME First Middle Last Minnie Watkins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 213-28-5528		17. INFORMANT Address Medical Records Department							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Thromboembolism, Massive, Pulmonary Arteries Less than 24 h Coronary Occlusion with Large Myocardial Infarct 16 months DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease with 10 years? (c) Marked Cardiac Hypertrophy (450 Gms)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO IMMEDIATE CAUSE Diabetes Mellitus											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) No accident involved.							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (the hospital) attended the deceased from January, 1935 , to November 7, 1968 , that (I) (we) last saw the deceased alive on November 6, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.											
22b. SIGNATURE M. McKendree Boyer, M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED November 8, 1968					
22d. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M.D.				22e. ADDRESS 9701 Church St., Damascus, Md. 20750							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 9, 1968		23c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.		23d. LOCATION (City or Town) (County) (State) Clagettville, Md.					
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.				25a. REC'D BY REGISTRAR NOV 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR M
EDWARD J.		BROSNAN JR						NOV 25 1968			2 30
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH Oct 7, 1914		6. AGE (In years lost birth, y)		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
13a. MARYLAND		13b. Montgomery		13c. Rockville		13d. YES		13e. 6501 Old Farm Lane.			
14. FATHER'S NAME First Middle Last		EDWARD J. BROSNAN SR.		15. MOTHER'S MAIDEN NAME First Middle Last		MARY HATCHELL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
YES		N.W.H.		578-38-743		MRS. LOIS L. BROSNAN		3905			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, generalized</u> 1621 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Primary bronchogenic carcinoma, left</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
1621											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>23 Sept 1968</u> to <u>25 Nov 1968</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Eugene P. Libre MD		22c. DATE SIGNED 25 Nov 1968		22d. PHYSICIAN'S NAME (Type) EUGENE P. LIBRE							
22e. ADDRESS 10400 Conn. Ave. Kensington Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11-29-1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Montgomery Co/ Md.					
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., N.W., Wash., D.C., 20016		25a. REC'D BY REGISTRAR NOV 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge							

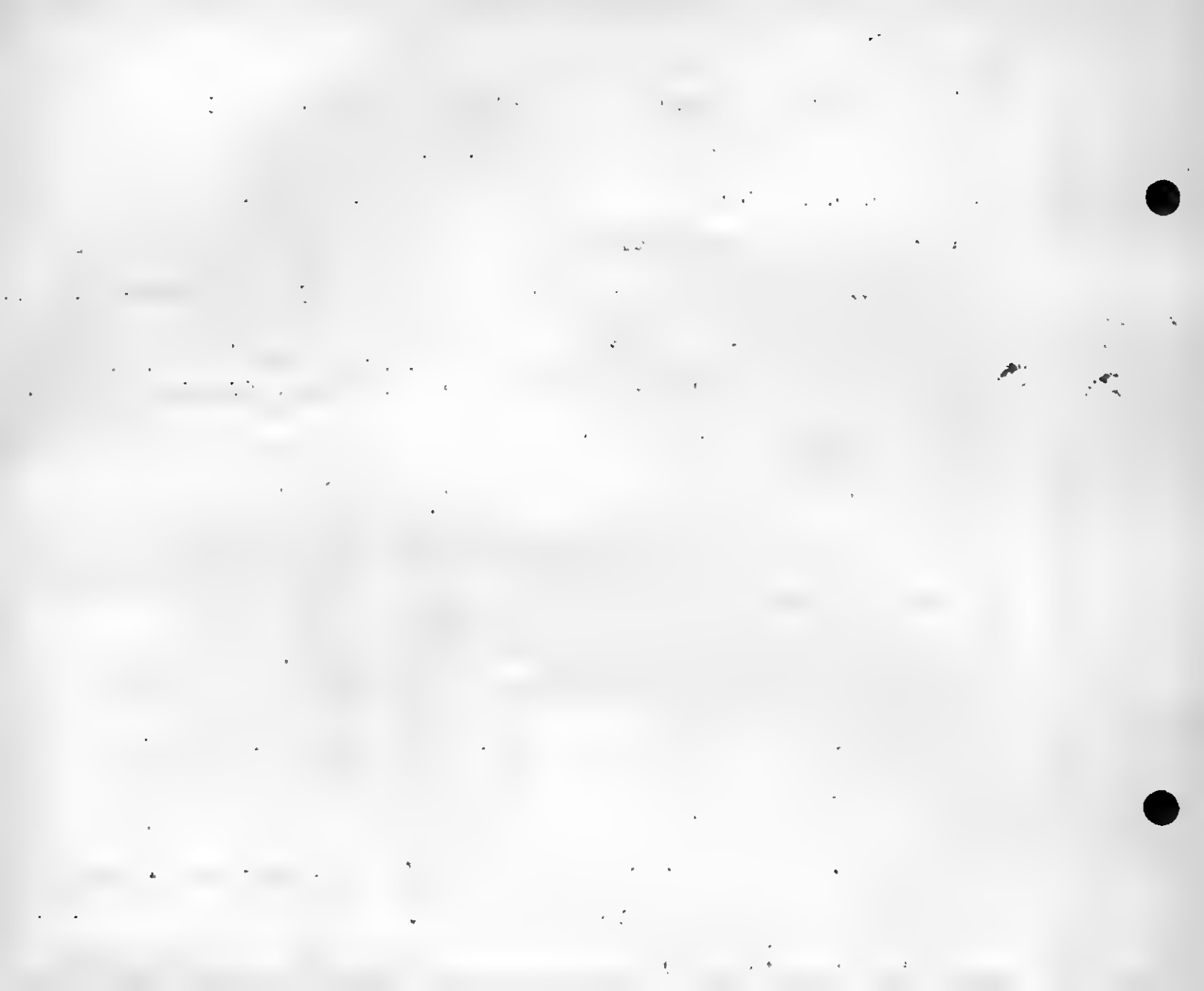


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 10 days after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) John Reginald BROSNAN					2a. DATE OF DEATH Month Nov. Day 19 Year 68			2b. HOUR 5:15A M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH Jul. 13, 1900		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Lawyer		12b. KIND OF BUSINESS OR INDUSTRY Law			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D. C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3511 Rittenhouse St., N.W.	
14. FATHER'S NAME First Middle Last John J. Brosnan			15. MOTHER'S MAIDEN NAME First Middle Last Mary A. Keefe						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO 579 60 1665		17. INFORMANT N.W. Washington Address D. C. Mrs. Angela C. Brosnan, 3511 Rittenhouse St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia 11/4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Squamous cell carcinoma in the neck DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) 1714									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Nov. 18 , 19 68 , to Nov. 19 , 19 68 , that (I) (we) last saw the deceased alive on Nov. 19 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>T. M. Schenk</i>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED Nov. 20			
22d. PHYSICIAN'S NAME (Type) T. M. SCHENK, M. D.				22e. ADDRESS Naval Hospital, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11-23-68		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington D. C.			
24. FUNERAL DIRECTOR Raymond J. Curran Funeral Home, Towson, Maryland				25a. REC'D BY REGISTRAR NOV 21 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16036									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <u>Hilda Buhl Brown</u>			2a. DATE OF DEATH 11 Month 8 Day Year 68			2b. HOUR 6:45 A M			
3. SEX <u>Female</u>		4. RACE <u>CAUCASIAN</u>		5. DATE OF BIRTH <u>6-24-1879</u>		6. AGE (In years last birthday) <u>89</u> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.			
10. CITY OR TOWN OF DEATH <u>Cherry Chase</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Bethesda-Silver Spring Nursing Home</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <u>Washington D.C.</u>		13b. COUNTY		13c. CITY OR TOWN <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>		13d. STREET AND NUMBER <u>3133 GUN AVE</u>			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>NO</u>		16b. SOCIAL SECURITY NO <u>-</u>		17. INFORMANT <u>10412 MONTROSE AVE., BETH., MD.</u> <u>MARY K. BRECHT, CONSERVATOR</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA OF ASCENDING COLON</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE FAILURE</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (the hospital) attended the deceased from <u>July 1, 1948</u> , to <u>Nov 8, 1948</u> , that (I) (we) last saw the deceased alive on <u>Nov 3, 1948</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>J. S. Sappington M.D.</u>				DEGREE <u>M.D.</u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>Nov 8, 1968</u>	
22d. PHYSICIAN'S NAME (Type) <u>F. S. SAPPINGTON</u>				22e. ADDRESS <u>2233 WISCONSIN AVE., NW. D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal-Burial</u>		23b. DATE <u>11-9-1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Smithfield Cemetery</u>		23d. LOCATION (City or Town) <u>Pittsburg, Penna.</u>		(County) (State)	
24. FUNERAL DIRECTOR <u>Joe Gawler's Sons Wash. D.C.</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE <u>NOV 12 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 days after death.

VR A15 (4)
30M REV 1/68

16037

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16051

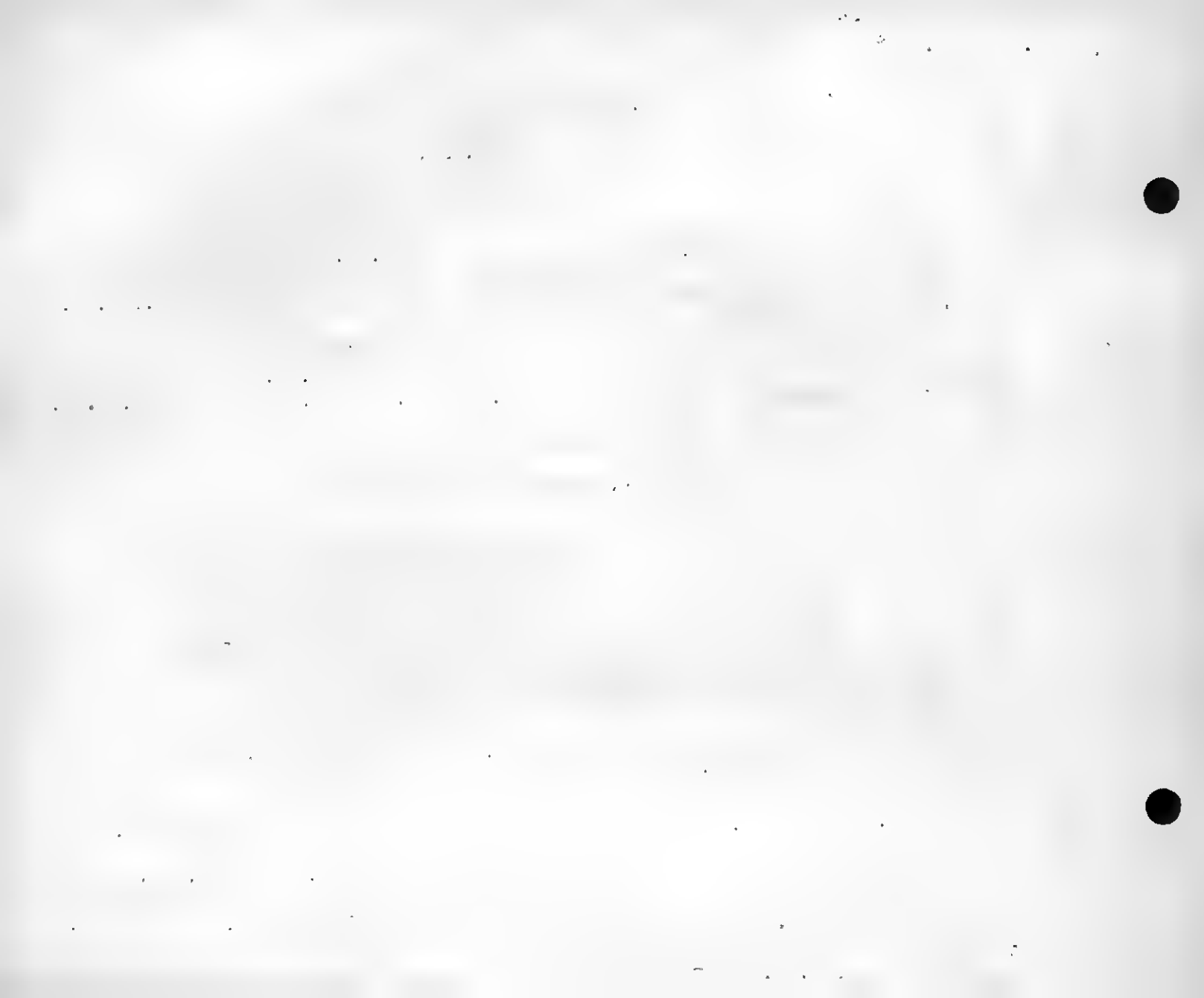
1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR Min		
SHERMAN		William		Brown, Jr.	11 14 68			12 4. M		
3 SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN	
Male	Cauc.		5/23/18		50 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Missouri		USA				Montgomery Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda		Grosvenor Lane Nursing Center								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM TST YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Virginia		Arlington		Arlington				1354 - 28th St. Arlington		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Sherman William Brown, Sr.					Frankie Harrison					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
Yes		WW 11		500-01-5137		Ann S. Brown-		1354 S. 28th St., Arl. Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1 DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
				cardiac arrest				5 min		
				DUE TO, OR AS A CONSEQUENCE OF		hypoglycemia		1 hour		
				(b)						
				DUE TO, OR AS A CONSEQUENCE OF		brittle diabetes		chronic		
				(c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or RFD No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from October, 1968, to Nov 14, 1968, that (I) (we) last saw the deceased alive on Nov 14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE	
David A. Morowitz, M.D.		11/14/68			David A. Morowitz		Bethesda, Md.		Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Rem-Burial		11/14/68		Tarkio Cemetery		Tarkio, Missouri				
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Murphy Funeral Home, Arlington, Va.							DATE NOV 18 1968			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																																			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																																			
16038 CERTIFICATE OF DEATH 16052																																			
1 DECEASED NAME (Type or print)			First George			Middle E.			Last BRYANT			2a. DATE OF DEATH Month November			Day 20			Year 68			2b HOUR 200P M														
3 SEX Male			4. RACE Caucasian			5. DATE OF BIRTH Feb. 21, 1892			6. AGE (In years last birthday) 76 YRS.			7c UNDER YEAR MONTHS			7d UNDER 24 HRS DAYS			7e UNDER 24 HRS HOURS			7f UNDER 24 HRS MIN														
7a. BIRTHPLACE (State or foreign country) Missouri			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery Md																										
10. CITY OR TOWN OF DEATH Bethesda						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U. S. Navy						12b. KIND OF BUSINESS OR INDUSTRY																	
13a. USUAL RESIDENCE (Where deceased lived if institution Reside before admission) STATE District of Columbia						13b. CITY OR TOWN OF RESIDENCE Washington						13c. STREET AND NUMBER 5100 Byers St., S. E.																							
14. FATHER'S NAME First Milton			Middle Bryant			Last Bryant			15. MOTHER'S MAIDEN NAME First Frances			Middle Martin			Last Martin																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						16b. SOCIAL SECURITY NO. 1919-1946						17. INFORMANT Washington, D. C. Mrs. Mary F. Bryant, 5100 Byers St. S. E.																							
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))																																			
PART 1 DEATH WAS CAUSED BY:																																			
IMMEDIATE CAUSE (a) Acute Pulmonary Edema																																			
DUE TO, OR AS A CONSEQUENCE OF																																			
(b) Chronic Pulmonary Emphysema																																			
DUE TO, OR AS A CONSEQUENCE OF																																			
(c)																																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																			
5271																																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work						21e. PLACE OF INJURY (At home farm, street, factory, OFFICE, BUILDING, ETC.)						21f. LOCATION Street or R.F.D. No City or Town County State																							
22a. I certify that (X) (this hospital) attended the deceased from Nov. 11, 19 68, to Nov. 20, 19 68, that (X) (we) last saw the deceased alive on Nov. 20, 19 68, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE Ashton Graybill																		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>						22c. DATE SIGNED 21 Nov. 1968											
22d. PHYSICIAN'S NAME (Type) Ashton GRABIEL LT MC USN																		22e. ADDRESS Naval Hospital, Bethesda, Md.																	
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE Nov. 23-68						23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery						23d. LOCATION (City or Town) (County) (State) Bladensburg, Md.																	
23e. FUNERAL HOME Simmons Brothers Funeral Home																		23f. ADDRESS Washington, D. C. 1661-Good Hope Rd SE						23g. REC'D BY REGISTRAR NOV 26 1968						23h. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA FORM 100-1 (1-68)
30M REV. 1-68

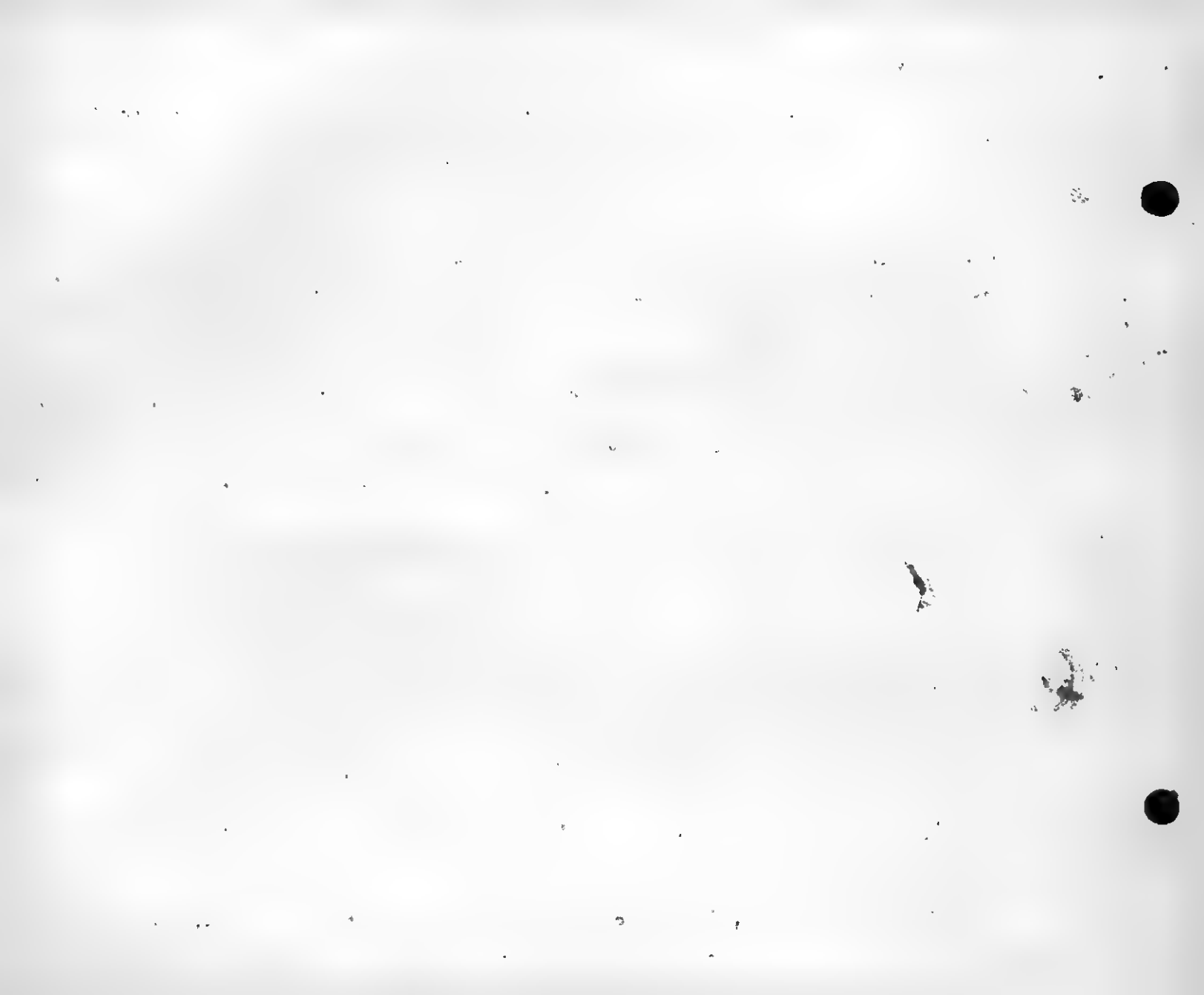
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1603

CERTIFICATE OF DEATH

16053

1. DECEASED-NAME (Type or print) Edward F. Burke			2a. DATE OF DEATH Month 11 Day 29 Year 1968			2b. HOUR 3:02 PM	
3. SEX male		4. RACE white		5. DATE OF BIRTH 10/28/197		6. AGE (in years lost birthday) 71 YRS.	
7a. BIRTHPLACE (State or foreign country) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) DRICK LAY		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 17908 BLUEBELLE		14. FATHER'S NAME First Middle Last JOHN BURKE		15. MOTHER'S MAIDEN NAME First Middle Last DELIA (UNKNOWN)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO 21-01-0510		17. INFORMANT Mr Harold ROUGHNIGHT		Address (Sawie)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiomyopathy failure DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 119a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11/28 , 19 68 , to 11/29 , 19 68 , that (I) (we) last saw the deceased alive on 11/28 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Henry M. Wise				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/29/68	
22d. PHYSICIAN'S NAME (Type) Henry M. Wise				22e. ADDRESS 1111 Spring Str t, Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Dec. 2, 68		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville Mont. Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler F.H. 1331				ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DEC 5 1968	
				25b. REGISTRAR'S SIGNATURE William J. Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

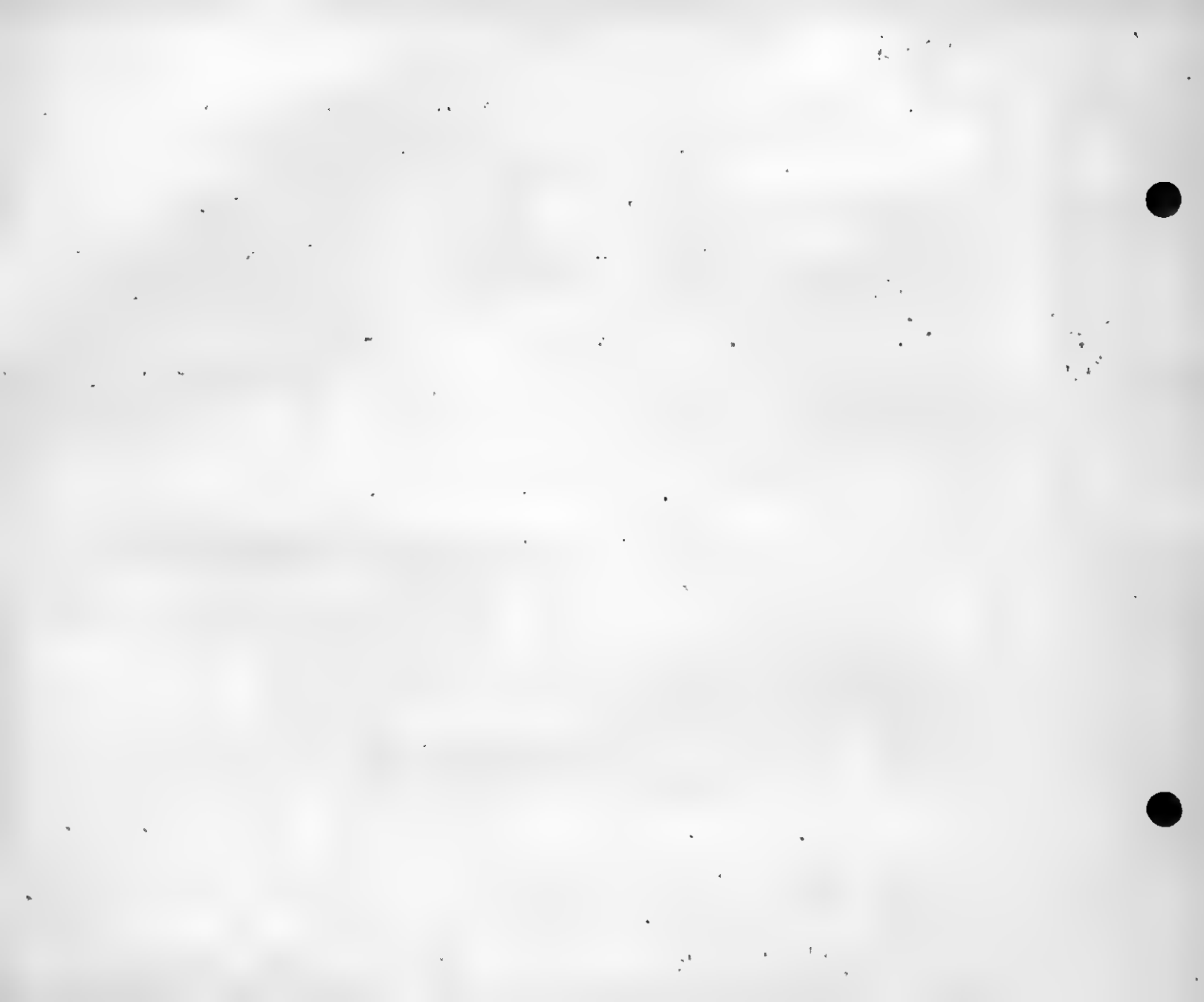
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16040

16054

1. DECEASED-NAME (Type or print) EDWARD R. BURKE			2a. DATE OF DEATH Month NOVEMBER Day 4 Year 1965			2b. HOUR 5:45 AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 11-28-1880		6. AGE (in years last birthday) 87 YRS.	
7a. BIRTHPLACE (State or foreign country) South Dakota		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Hall Sanitarium		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired U.S. Senator		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Patrick Middle D. Last Burke		15. MOTHER'S MAIDEN NAME First Mary Middle Nolan Last Nolan		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes (If yes, give year or dates of service) W.W.I.			
16b. SOCIAL SECURITY NO 579-26-5581A		17. INFORMANT Claridge Address Road, Wheaton, Md. Mrs. Beatrice B. Bean, Daughter, 11920					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 4120 DUE TO, OR AS A CONSEQUENCE OF (b) ESSENTIAL HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 444X SENILITY							—
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER, 1965 , to NOVEMBER 4, 1965 , that (I) (we) last saw the deceased alive on NOVEMBER 4, 1965 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Henry M. Lowden, M.D.				22c. DATE SIGNED 11/4/68		22d. PHYSICIAN'S NAME (Type) Henry M. Lowden, M.D.	
22e. ADDRESS 5206 Norway Dr. Chevy Chase, Md.				22f. ADDRESS 5206 Norway Dr. Chevy Chase, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-7-1968		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Prince Georges Co., Md.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016				25a. REC'D BY REGISTRAR DATE NOV 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16041

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10056

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last FRANCIS HOLCOMB BURNHAM			2a. DATE OF DEATH Month 11 Day 11 Year 68			2b. HOUR 3:20 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 5-27-96		6. AGE (In years last birthday) 72 YRS.	
7a. BIRTHPLACE (State or foreign country) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY	
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) STEAM ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last FRANK W. BURNHAM		15. MOTHER'S MAIDEN NAME First Middle Last FANNY - HOLCOMB					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) YES		16b. SOCIAL SECURITY NO. 108-01-4630		17. INFORMANT Address MEDICAL RECORD DEPT.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis - infarction, left DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis, General Coronary, Renal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4-1-1							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 days years. years.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Previous Cerebral Thrombosis - right							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Sept , 19 67 , to Nov , 19 68 , that (I) (we) last saw the deceased alive on Nov 11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. A. Yates, M.D.				22c. DATE SIGNED 11/12/68			
22d. PHYSICIAN'S NAME (Type) R. A. YATES, M. D.				22e. ADDRESS OLNEY, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 11/13/68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Prince George Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home				25a. REC'D BY REGISTRAR NOV 15 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Items 18-22a Film 407 Maryland State Department of Health
12-12-68 and DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16042

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First BRIAN		Middle B.		Last BUTLER		2a. DATE KNOWN OF ESTI DEATH MATED <input checked="" type="checkbox"/> 11 26 1968		2b. HOUR 3:45 P M	
3 SEX Male	4. RACE White	5. DATE OF BIRTH 11/20/1950		6. AGE (in years last birthday) 18 YRS	7. UNDER YEAR MONTHS DAYS HOURS MIN		8. DATE PRONOUNCED DEAD Month 11 Day 26 Year 1968		2d. HOUR 3:45 P M		
7a. BIRTHPLACE (State or foreign country) Trieste		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.				2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CLERK-		12b. KIND OF BUSINESS OR INDUSTRY DAILY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3421 Floral St.			
14. FATHER'S NAME First Ben Middle Burr Last Butler		15. MOTHER'S MAIDEN NAME First Mary Middle A. Hoff Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (if yes give war or dates of service) UNKNOWN		17. INFORMANT ADDRESS Mary A. Butler 3421 Floral St. Wheaton, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot wound of chest with 965X DUE TO, OR AS A CONSEQUENCE OF exsanguination Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 3:45 P M 11-26 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Deceased was shot by his brother after dispute about car.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f. LOCATION Street or R.F.D. No.		City or Town Silver Spring		County Montg.		State Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Belden R. Reap MD				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED Nov. 26, 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3 DECEMBER 68		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT. CEMETERY		23d. LOCATION (City or Town) (County) (State) ARLINGTON VA.					
24. FUNERAL DIRECTOR RINALDI FUNERAL HOME INC. 7400 GEORGIA AVE. N.W.		ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 2 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

160423

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16951

1. DECEASED NAME (Type or print) ROBERT First EUGENE Middle CAMPBELL Last			2a. DATE OF DEATH Month Nov. Day 15 Year 68		2b. HOUR 4:40 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH FEB 1, 1892		6. AGE (In years last birthday) 76 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (State or foreign country) PENNA		7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY Md	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) FAIRLAND NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) WELDER	12b. KIND OF BUSINESS OR INDUSTRY MEADE MD
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD		13b. COUNTY PR. GEORGE'S	13c. CITY OR TOWN LAUREL	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER LOT # 4 FRANCIS ST
14. FATHER'S NAME First DANIEL Middle DUNCAN Last OLIVER			15. MOTHER'S MAIDEN NAME First ANNA Middle JANE Last RICHARDS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO 193-09-7898		17. INFORMANT MRS MARTHA CAMPBELL Address 4 FRANCIS ST. LAUREL MD 20710	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4367 BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) C.S. - C. - V.A. DUE TO, OR AS A CONSEQUENCE OF (c) Heart: A.S. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Days 6 1/2 yrs 15 yrs					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Metastatic Co. Prostate					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (If either natly med cal examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCAT ON Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 12/25, 1963 to 11/14, 1968 , that (I) (we) lost saw the deceased alive on 11/13, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death.					
22b. SIGNATURE J. M. Warren MD				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) JOHN M. WARREN, M.D.				22e. ADDRESS 321 PRINCE GEORGE ST, LAUREL, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11/18/68		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	
23d. LOCATION (City or Town) SUITLAND MD.		23e. COUNTY PRINCE GEORGE'S		23f. STATE MD.	
24. FUNERAL DIRECTOR LAUREL FUNERAL HOME 550 WASH. BLVD.				25a. REC'D BY REGISTRAR NOV 19 1968	
25b. REGISTRAR'S SIGNATURE [Signature]				25c. JUDGE'S SIGNATURE [Signature]	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16053	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR	
Patricia		Dorian		Cantwell				11 30 68		1:30	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)	7 MONTHS		8 YEARS		2c DATE PRONOUNCED DEAD		2d HOUR
female	cauc.	9/30/50		18					11 30 68		4:46
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
		U.S.A.				Montgomery		Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Silver Spring		Holy Cross		STUDENT							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Va.				Alexandria				1115 Aiden Rd.			
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS	
William P		CANTWELL		Helen		Cantwell					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))											
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Crushed Chest											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Trauma - from Auto Accident											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
823.4											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		11 30 1968		Passenger in car went out of control Turned over							
21d INJURY OCCURRED		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Highway 495		Between Corra Ave + George		Cherry Chase		Montgomery		Md.	
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED	
John S. Bell										Nov. 30, 1968	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		Dec 5 1968		Arlington National		Arlington				Va	
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE							
Demaine Funeral Home		5205 Washington		DEC 3 1968		Charles Judge					

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTIMATED DEATH			2b HOUR
JOHN LEONARD CARTER						Month Day Year			7:10 PM
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years lost birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD
Male	W	July 2 1968		4 YRS	MONTHS DAYS		HOURS MIN		Month Day Year
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Maryland		U.S.A.				Montgomery Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Baltimore		Suburban			Child				
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md		Mont		Rockville				805 Jefferson St.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
			Geraldine Curry						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS				
					Mrs. Scott - Welfare Department-Montg. Co.				
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>2ndary Anoxemia</u>									<u>Sudden</u>
7:10 PM DUE TO, OR AS A CONSEQUENCE OF (b) <u>Crib Death</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
7620									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		Hour A.M. P.M.		19					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County	State
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b. DATE SIGNED	
John G. Ball								Nov 10, 1968	
EXAMINER'S NAME (Type)		John G. Ball-Bethesda, Md.		ADDRESS (Street, city, town, or county)					
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)
Burial		11/15/68		Forest Oak		Gaithersburg		Lo. t.	Md.
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Tyson Wheeler Funeral Home				1331 Rockville Pike Rockville, Md.		NOV 15 1968		Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16046									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) XXXX Nettie			First Middle Last — Cathcart			2a. DATE OF DEATH Month Nov. Day 3 Year 68		2b. HOUR 5:35 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 1/10/92		6. AGE (In years last birthday) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S. 7.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Co.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) XXXXXX		12b. KIND OF BUSINESS OR INDUSTRY XXXXXX			
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 733 Sligo Ave Apt. 305	
14. FATHER'S NAME First Middle Last James			15. MOTHER'S MAIDEN NAME First Middle Last Anna						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown XXXXXX		16b. SOCIAL SECURITY NO 363-10-5355		17. INFORMANT Miss Della Brewer		Address Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease + Pulmonary emphysema								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days gr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4 x x x x									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from Nov. 2, 1965 , to Nov. 3, 1968 , that (1) (we) lost saw the deceased alive on Nov. 2, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James R. Coleman MD.				DEGREE MD.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Nov. 3, 1968	
22d. PHYSICIAN'S NAME (Type) JAMES R. COLEMAN MD				22e. ADDRESS 9241 COLUMBIA BLVD SILVER SPRING MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11-5-1968		23c. NAME OF CEMETERY OR CREMATORY St. Mary's National Co.		23d. LOCATION (City or Town) (County) (State) St. Mary's, Illinois			
24. FUNERAL DIRECTOR M. Andrew Duvall				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge			
DATE NOV 7 1968									



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VR 111
45M

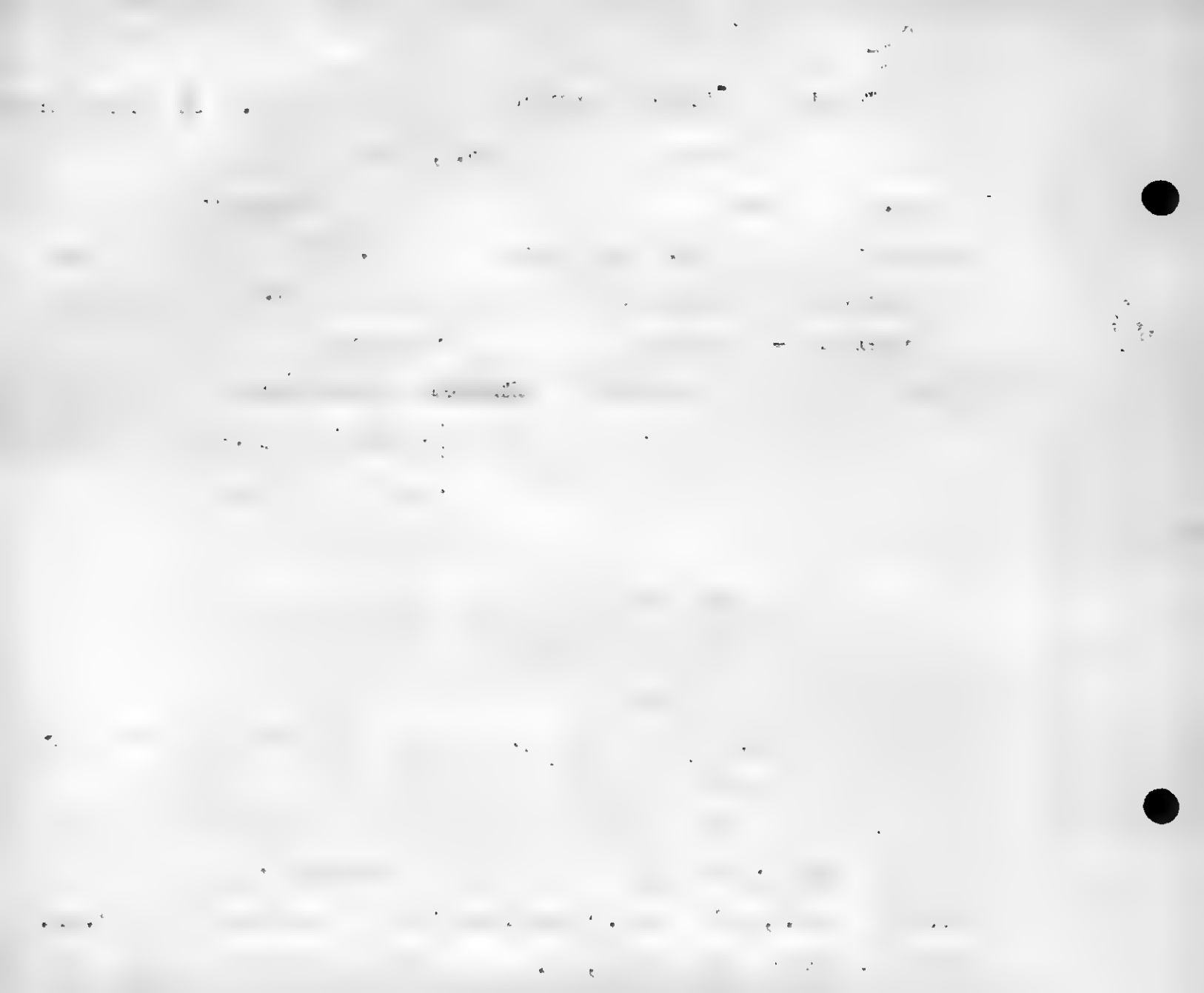
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) <i>Katherine R. Chaney</i>			First Middle Last			2a DATE OF DEATH Month Day Year <i>Nov. 24, 1968</i>		2b HOUR <i>10:30</i>	
3 SEX <i>female</i>		4 RACE <i>white</i>		5 DATE OF BIRTH <i>11/18/22</i>		6 AGE (In years last birthday) <i>46</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>Alabama</i>		7b CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Housewife</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY <i>Sp. Home</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>MD</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Wheaton</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>12020-Tudson Rd.</i>	
14 FATHER'S NAME First Middle Last <i>Harner McLain</i>			15 MOTHER'S M A DEN NAME First Middle Last <i>Ollie Strickland</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b SOCIAL SECURITY NO <i>417-14-6497</i>		17 INFORMANT <i>Walter E. Goetz</i>		Address <i>same as above</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of kidney</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>June, 1968</i> to <i>Nov. 1968</i> , that (I) (we) last saw the deceased alive on <i>24 Nov. 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Walter E. Goetz</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>11/25/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>WALTER E. GOETZ</i>				22e. ADDRESS <i>WHEATON, MARYLAND</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Nov. 27, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>			
24. FUNERAL DIRECTOR <i>W.W. Chambers Co.</i>		ADDRESS <i>8655 Ga Ave Silver Spring, Md</i>		25a. REC'D BY REGISTRAR <i>NOV 29 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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VR 1514
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16048									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Fannie Etchison Chrobot						2a. DATE OF DEATH Month Nov. Day 28 Year 1968		2b. HOUR 10:40A	
3. SEX F		4. RACE White		5. DATE OF BIRTH Aug. 3, 1886		6. AGE (in years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Germantown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Md. Home of Rest		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) H. wife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Etchison		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. #2	
14. FATHER'S NAME First Middle Last Marcellus - Etchison				15. MOTHER'S MAIDEN NAME First Middle Last Fannie King					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Home Records Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of left breast gland metastases DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 174X (b) Chronic atherosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 YEARS 10 YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from 10/18 19 61 , to 11/28 19 68 , that (I) (we) last saw the deceased alive on 11/20 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE James P. Kerr M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/30/68	
22d. PHYSICIAN'S NAME (Type) James P. Kerr				22e. ADDRESS Damascus, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Mont. United Methodist		23d. LOCATION (City or Town) (County) (State) Claggettsville Mont. Md.			
24. FUNERAL DIRECTOR Francis H. Barber				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DEC 3 1968		25b. REGISTRAR'S SIGNATURE <i>Glenn L. Young</i>	



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16049		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				16063	
1. DECEASED NAME (Type or print) First Middle Last SAMUEL MARION CLARK						2a. DATE OF DEATH Month Day Year 11-25-68	
3 SEX M		4. RACE W		5. DATE OF BIRTH 1-22-86		6 AGE (In years lost birthday) 82 YRS.	
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONT	
10. CITY OR TOWN OF DEATH TAK. PK.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. SEN		12a USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired.) FATHER		12b KIND OF BUSINESS OR INDUSTRY Retired	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before adm ssion) STATE MD.		13b COUNTY P.G.		13c CITY OR TOWN ADDELPHI		13d INSIDE CITY (HATS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 8410 ADDELPHI RD		14. FATHER'S NAME First Middle Last MARION CLARK		15 MOTHER'S MAIDEN NAME First Middle Last HARRIET WILKINS			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) III		16b SOCIAL SECURITY NO 235 60 3065		17 INFORMANT GRANDSON		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchial Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 485X 497X							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Right Dehydration, Goat							
19a. DATE OF OPERATION		19b. CONDITION OR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from January, 1966 , to 11-29, 1968 , that (I) (we) lost saw the deceased alive on 11-22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b SIGNATURE Stuart Nelson				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 11-29-68	
22d PHYSICIAN'S NAME (Type) Stuart L. Nelson				22e ADDRESS 83 University Blvd Silver Springs, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Dec 1, 1968		23c NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery		23d LOCATION (City or Town) (County) (State) Baner Hardy West Va	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE DEC 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



1
16050

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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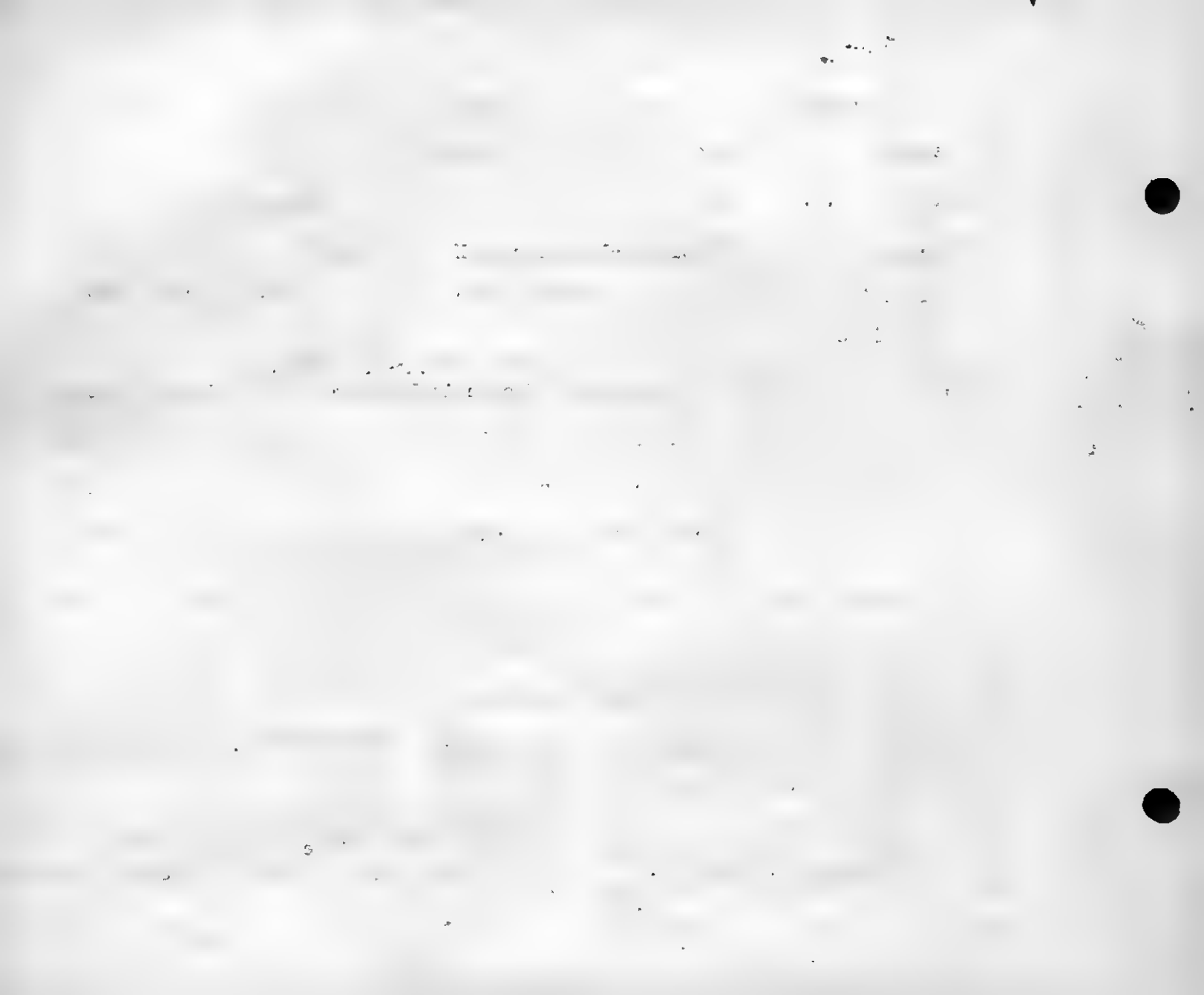
16064

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
1 DECEASED NAME (Type or print)		First <u>James</u>		Middle <u>W.</u>		Last <u>Clinite</u>		2a. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>68</u>		2b. HOUR <u>12:30</u> M	
3 SEX <u>male</u>		4 RACE <u>white</u>		5. DATE OF BIRTH <u>7-18-24</u>		6 AGE (In years last birthday) <u>44</u> YRS.		IF UNDER 1 YEAR MONTHS <u>11</u> DAYS <u>11</u>		IF UNDER 24 HRS. HOURS <u>12</u> M <u>30</u>	
7a. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md					
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Machinist</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Industry</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>		13b. CITY <u>Montg.</u>		13c. CITY OR TOWN <u>Sil. Spr.</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>809 Richmond Avenue</u>			
14. FATHER'S NAME First <u>Raymond G.</u> Middle <u>Clinite</u> Last <u>Moore</u>		15. MOTHER'S MAIDEN NAME First <u>Ruth</u> Middle <u>Moore</u> Last <u>Moore</u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <u>No</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <u>Yes</u>		17. INFORMANT Address <u>Silver Spring, Md.</u> <u>Mrs. Ruth Clinite 809 Richmond Avenue</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subacute pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>E secondary Klebsiella pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>lost.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month.</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>0051</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes.</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (1) (this hospital) attended the deceased from <u>10/28, 1968</u> , to <u>11/10, 1968</u> , that (1) (we) last saw the deceased alive on <u>11/10, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>James R Coleman MD</u>		DEGREE <u>MD</u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>Nov. 11, 1968</u>					
22d. PHYSICIAN'S NAME (Type) <u>JAMES R COLEMAN MD</u>		22e. ADDRESS <u>9241 COLUMBIA BLVD SILVER SPRING MARYLAND</u>									
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-13-1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Hyattsville Pr. Geo. Md.</u>					
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</u>		ADDRESS <u>Sil. Spr. Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 14 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Cynthia	Middle Ann	Last Cohen	2a. DATE OF DEATH Month November Day 29 Year 1968			2b. HOUR 5:00 M
3 SEX Female		4. RACE White		5. DATE OF BIRTH 13 May 1948		6. AGE (In years last birthday) 20 YRS		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) The Clinical Center, NIH				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) - STATE Virginia		13b. COUNTY Falls Church		13c. CITY OR TOWN Falls Church		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3031 Westlawn Place	
14. FATHER'S NAME First Sidney Middle Cohen Last Cohen			15. MOTHER'S MAIDEN NAME First Leona Middle Schwartz Last Schwartz						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 227-70-6645		17. INFORMANT Bethesda, Maryland Address The Medical Records, The Clinical Center,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Aspiration Pneumonia 2050 DUE TO, OR AS A CONSEQUENCE OF (b) Seizure disorder DUE TO, OR AS A CONSEQUENCE OF (c) Acute Myelocytic Leukemia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 Days 12 Days 2 Months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 2-4									
19a. DATE OF OPERATION 2-4		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that XX (this hospital) attended the deceased from 4 October , 19 68 , to 29 Nov. , 19 68 , that (X) (we) last saw the deceased alive on 29 November , 19 68 , and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above (XX) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Harmon J. Eyre						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 29 November 1968	
22d. PHYSICIAN'S NAME (Type) Harmon J. Eyre, MD.						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE DEC 7, 1968		23c. NAME OF CEMETERY OR CREMATORY Kennelwood Memorial Park		23d. LOCATION (City or Town) (County) (State) Bethesda, Md.			
24. FUNERAL DIRECTOR Soldberg Funeral Home						25a. REC'D BY REGISTRAR DEC 3 1968		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared With Medical Examiner

16052										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16066									
1. DECEASED NAME (Type or print) First Middle Last David Jack Cohen										2a. DATE OF DEATH Month Day Year November 17 1968										2b. HOUR am pm 10:10									
3. SEX Male					4. RACE Caucasian					5. DATE OF BIRTH July 15, 1918					6. AGE (In years last birthday) 50 YRS					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) Trenton, N.J.					7b. CITIZEN OF WHAT COUNTRY? United States					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Montgomery County Md.														
10. CITY OR TOWN OF DEATH Norbeck					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery Gen. Hosp.					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Merchant					12b. KIND OF BUSINESS OR INDUSTRY Men's Wear														
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland					13b. COUNTY Montgomery					13c. CITY OR TOWN Silver Spring					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 9306 HARVEY Road									
14. FATHER'S NAME First Middle Last Samuel Cohen					15. MOTHER'S MAIDEN NAME First Middle Last Sarah Kravitz																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no					16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 578-32-588c					17. INFORMANT Theodore Smith,					Address Kensington, Md. 4015 Spruell Drive														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from Feb 1967, to Nov 17, 1968, that (I) (we) lost the deceased alive on Dec 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE Morton W. Shapiro, M.D.										22c. DATE SIGNED November 17, 1968																			
22d. PHYSICIAN'S NAME (Type) Morton W. Shapiro, M. D.										22e. ADDRESS 8107 Eastern Ave., Silver Spring, Md.																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE 11/19/68					23c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEM.					23d. LOCATION (City or Town) (County) (State) HYATTSVILLE, P.G., Md.														
24. FUNERAL DIRECTOR B. Dunnington Sons										ADDRESS 301 W. Preston St. NW Nash D.C.										25a. REGISTRAR'S SIGNATURE NOV 19 1968					25b. REGISTRAR'S SIGNATURE				



16053

16053

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Wash., D. C. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chevy Chase Nursing Center				d. STREET ADDRESS 1375 Underwood St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PHILIP Middle H. Last COHEN				4. DATE OF DEATH Month 11 Day 6 Year 1968			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/1/1890	
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Yeshayohn Cohen				14. MOTHER'S MAIDEN NAME ---			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Tessie Cohen, 1375 Underwood St. NW	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 DUE TO Generalized arteriosclerosis & arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Acute DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 Bronchiopneumonia						INTERVAL BETWEEN ONSET AND DEATH 10 days, 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 , 19 to 11-6-68 , that I last saw the deceased alive on 11-5-68 , and that death occurred at 3:55 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James D. Burns M.D. 1835 1st St. N.W. DATE SIGNED 11-6-68				PHYSICIAN'S NAME (Type) JAMES D. BURNS Washington DC 20006			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/8/68		22c. NAME OF CEMETERY OR CREMATORY Beth Shalom Cemetery		22d. LOCATION (City, town, or county) (State) Hillside, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons ADDRESS 3501 14th St. NW Wash., D.C.				24a. REC'D BY REGISTRAR DATE NOV 12 1968		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
1. DECEASED-NAME (Type or print)		First MARY		Middle J.		Last CONNER		2a. DATE OF DEATH Month 11 Day 27 Year 68		2b. HOUR- 9:35 AM	
3. SEX F		4. RACE W		5. DATE OF BIRTH 5-23-92		6. AGE (In years last birthday) 76 YRS		IF UNDER 1 YEAR MONTHS 6 DAYS 4		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Bethesda, Maryland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Grosvenor Lane Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY NONE					
13a. U.S.A. RESIDENCE (Where deceased lived, if institut on. Res.dence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Garrett Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10902 Clermont Ave.			
14. FATHER'S NAME First William		Middle S.		Last Stryker		15. MOTHER'S MAIDEN NAME First Mary		Middle Hatfield		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-54-5042		17. INFORMANT Mrs. William M. Holland, same address					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE 457.9 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last, - 34x										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHRONIC LYMPHATIC LEUKEMIA											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from about 1964, to 11/27, 1968, that (I) (we) last saw the deceased alive on 11/27 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard H. Pollen MD		22c. DATE SIGNED 11/27/68		22d. PHYSICIAN'S NAME (Type) RICHARD H. POLLEN MD		22e. ADDRESS 10400 CONNECTICUT AVE., KENSINGTON, Md					
23a. BURIAL, CREMATION, REMOVAL DISPOSITION		23b. DATE 12-2-68		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va.					
24. FUNERAL DIRECTOR Robert A. Pumphreys 7557 Wisconsin Ave., Bethesda, Md.						25a. REC'D BY REGISTRAR DATE DEC 4 1968		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED WITH MEDICAL EXAMINER

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16055									
16060									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) CLaire BANKS			First Middle Last			2a DATE OF DEATH		2b HOUR	
3 SEX FEMALE			4 RACE White		5 DATE OF BIRTH Nov. 8, 1876		6 AGE (In years last birthday) 92 YRS.		2b HOUR 12:45 M
7a BIRTHPLACE (State or foreign country) BROOKLYN, N.Y.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery		12b KIND OF BUSINESS OR INDUSTRY	
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ALTHEA HOSPITAL 1000 DALEVIEW PL.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TELEPHONE R-RET.		12b KIND OF BUSINESS OR INDUSTRY EDUCATION			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE D.C.			13b COUNTY WASHINGTON		13c CITY OR TOWN WASHINGTON		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2301 CONN. AVE, N.W.
14 FATHER'S NAME First Middle Last John BANKS			15 MOTHER'S M.A.DEN NAME First Middle Last Ellen HALL						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO 577-462411		17 INFORMANT Ruth Robinson R.N.		Address 2335-15 St N.W. WASH. D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT									
4:69 DUE TO, OR AS A CONSEQUENCE OF									
(b) ARTERIOSCLEROTIC VASCULAR DISEASE									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
FRACTURE LEFT ISCHIO PUBIC RING									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY 9 A.M. - 7:29 Hour A.M. Month Day Year 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) FELL IN BATHROOM					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) HOME		21f LOCATION Street or R.F.D. No 6108 WELBORN DR		City or Town WHEELERS		County MONT State Md	
22a. I certify that (I) (this hospital) attended the deceased from Aug , 19 68 , to Nov , 19 68 , that (I) (we) last saw the deceased alive on 11-8 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Bernard A. Fitzgerald MD				DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11-9-68	
22d. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD				22e ADDRESS 217 Univ. Bldg E, Silver Spring, Md					
23a BURIAL, CREMATION, BOWNE (Specify)		23b DATE 11-12-1968		23c NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City or Town) Washington, D.C.		(County) (State)	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 3130 Wisc. Ave. N.W., Wash., D.C., 20016				ADDRESS		25a REC'D BY REGISTRAR NOV 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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MAY 1968										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16050									
16058										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print) Daniel Peter Corey										2a. DATE OF DEATH November 19 1968										2b. HOUR 11:00 AM									
3 SEX Male					4 RACE White					5 DATE OF BIRTH 8 April 1922					6 AGE (in years last birthday) 46 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) Rhode Island					7b. CITIZEN OF WHAT COUNTRY? USA					8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Montgomery Md														
10. CITY OR TOWN OF DEATH Bethesda					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mechanic					12b. KIND OF BUSINESS OR INDUSTRY US Gov't														
13a. USUA. RES. DENCE (Where deceased lived, if institution: Residence before admission) STATE Pennsylvania					13b. COUNTY Philadelphia					13c. CITY OR TOWN Philadelphia					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 2926 South 15th Street									
14. FATHER'S NAME First Manuel Middle Corey Last Anna					15. MOTHER'S MAIDEN NAME First Anna Middle Raposa Last Raposa																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give dates of service) Yes 1943-45					16b. SOCIAL SECURITY NO. 039-05-4709					17. INFORMANT Bethesda, Maryland Address The Medical Records, The Clinical Center,																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastrointestinal bleeding															3 weeks														
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic myelogenous leukemia															4 years														
DUE TO, OR AS A CONSEQUENCE OF (c) 																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumonia																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (this hospital) attended the deceased from 20 October, 1968 , to 19 Nov. 1968 , that (we) lost saw the deceased alive on 19 November 1968 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.																													
22b. SIGNATURE P. J. Rosen M.D.										22c. DATE SIGNED 19 November 1968																			
22d. PHYSICIAN'S NAME (Type) Peter J. Rosen, M.D.										22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE Nov. 23, 1968					23c. NAME OF CEMETERY OR CREMATORY St. Peters & Pauls					23d. LOCATION (City or Town) (County) (State) Marple Del. Co. Pa.														
24. FUNERAL DIRECTOR Tyson Wheeler F. H. 1331 Rockville Pk. Rockville, Maryland										25a. REC'D BY REGISTRAR DATE NOV 21 1968					25b. REGISTRAR'S SIGNATURE W. C. ...														

1. The first part of the report
describes the general situation
of the country and the
state of the economy.
It also mentions the
political situation and
the state of the
army.

2. The second part of the report

describes the situation in the
provinces and the state of the
economy in each of them.
It also mentions the
political situation and
the state of the
army in each of them.

16057

CERTIFICATE OF DEATH

16071

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Elizabeth's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FREDERICK HUNTON COX</u>		4. DATE OF DEATH Month Day Year <u>October 1 19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1892</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Banker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Finance</u>	
11. BIRTHPLACE (State or foreign country) <u>New Baltimore, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Leonard Cox</u>		14. MOTHER'S MAIDEN NAME <u>Louise Hunton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>7-10-2501</u>	
17. INFORMANT <u>4701 Land Over Lane,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart disease</u> <u>4407</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH: <u>2 months</u> <u>6 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>T500</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 15, 1967</u> to <u>Nov 19, 1968</u> , that I last saw the deceased alive on <u>11/19, 1968</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6450 Wisconsin Ave, Bethesda, Md.</u> DATE SIGNED <u>11/19/68</u>			
ACTUAL SIGNATURE <u>Dr Joseph P. Kenrich</u> M.D.		DATE SIGNED <u>11/19/68</u>	
PHYSICIAN'S NAME (Type) <u>Dr JOSEPH P. KENRICH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11/21/68</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bethesda, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>7057 Wisconsin Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 26 1968</u>	
		24b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

16058

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

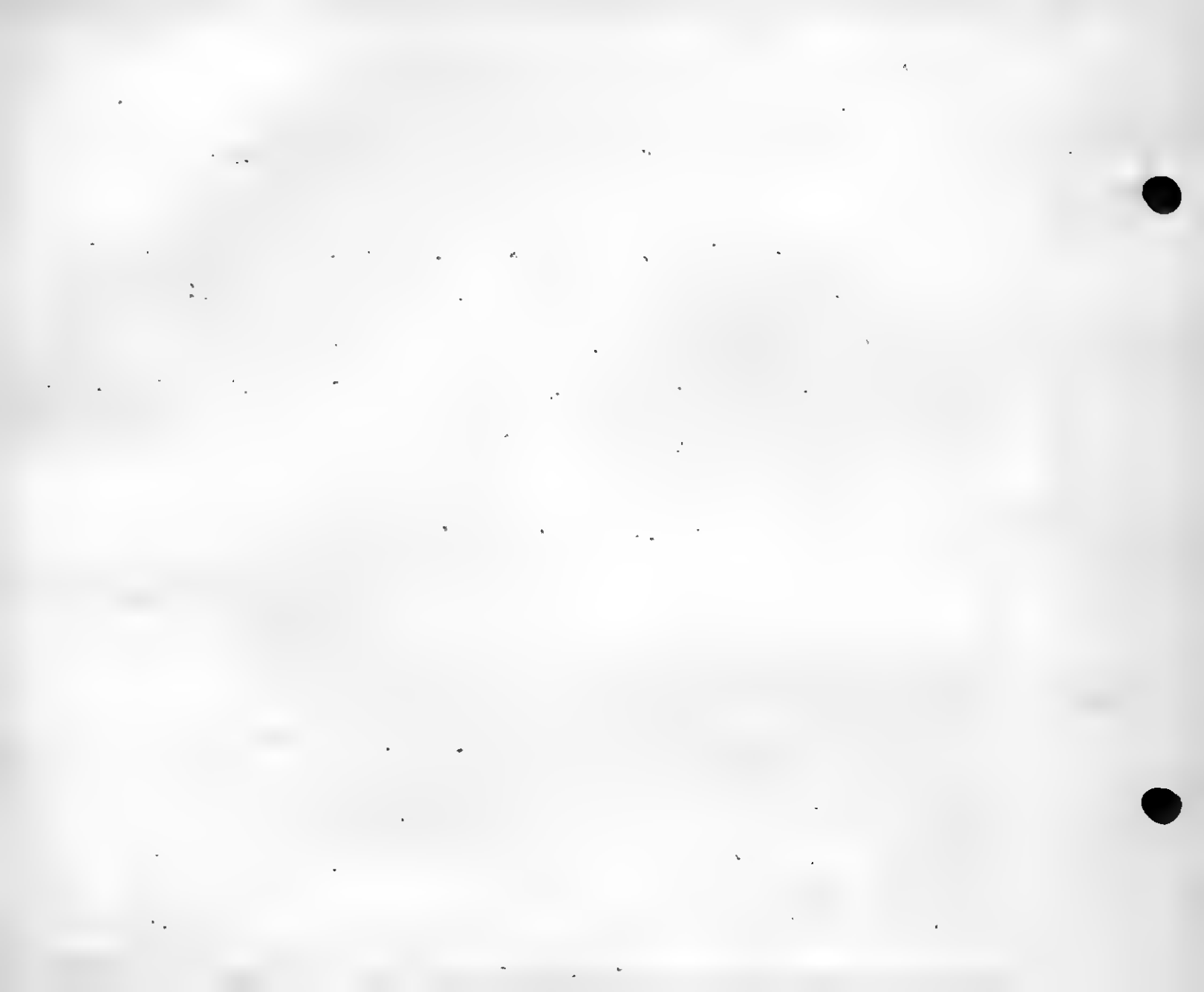
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First PERLEY		Middle M.		Last CROSS		2a. DATE KNOWN OF DEATH ESTIMATED Month Day Year 11 11 1968				2b. HOUR 4:20 PM		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 5/16/1899		6 AGE (In years last birthday) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year Nov. 11 1968				2d HOUR M
7a BIRTHPLACE (State or foreign country) Canada		7b CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md								
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Real Estate Salesman				12b. KIND OF BUSINESS OR INDUSTRY Real Estate				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		13e. STREET AND NUMBER 621 Gist Avenue				
14. FATHER'S NAME First Middle Last Eugene Cross				15. MOTHER'S MAIDEN NAME First Middle Last Cora Lamonda										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS Eyelyn L. Cross 621 Gist Ave., Sil. Sp., Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Artery Hardening Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4001</u>														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Belden R. Reap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City, Town or County) 201 1st St. N.W. Washington, D.C. 20002				22b. DATE SIGNED 11/11/1968						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE Nov. 14-1968		22c. NAME OF CEMETERY OR CREMATORY St. Lincoln				22d. LOCATION (City or Town) (County) (State) Hagerstown P. Res. Md.				
24. FUNERAL DIRECTOR J. W. Waters				25a. REC'D BY REGISTRAR DATE NOV 15 1968				25b. REGISTRAR'S SIGNATURE Charles Judge						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 14 File # 11/11/68		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		16073
16059		CERTIFICATE OF DEATH		
1. DECEASED-NAME (Type or print) First Middle Last Evelyn L. Crovo			2a. DATE OF DEATH Month Day Year 11 - 1 - 1968	
3 SEX Female	4 RACE White	5. DATE OF BIRTH 9-26-1921		2b. HOUR 8:26 A.M.
6 AGE (in years last birthday) 47 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. COUNTY OF DEATH Montgomery Md.
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Colonial Villa Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired
12b. KIND OF BUSINESS OR INDUSTRY UNIV. BLVD E.		13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md - Prince Georges		13b. CITY OR TOWN Langley Park
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER XXIX XXIX-1352		
14. FATHER'S NAME First Middle Last Arlia Holbrook		15. MOTHER'S MAIDEN NAME First Middle Last Margaret Johns		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. 579-01-6433A		17. INFORMANT Augustine Crovo, 8116-15th Ave., Langley Park, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer, liver</u> 1560 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer gall bladder</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mos. 6 mos.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from June, 1968, to Nov. 1, 1968, that (I) (we) last saw the deceased alive on Oct. 29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE A.W. Smith M.D.		22c. DATE SIGNED 11/1/68		
22d. PHYSICIAN'S NAME (Type) A.W. SMITH		22e. ADDRESS 13018 GEORGIA AVE WHEATON, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11-5-1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery
23d. LOCATION (City or Town) (County) (State) Princ Georges, Md.				
24. FUNERAL DIRECTOR E. P. Phelan, Jr.		25a. REC'D BY REGISTRAR DATE NOV 7 1968		25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers (pages 1 and 2) and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16060 CERTIFICATE OF DEATH 16074											
1. DECEASED-NAME (Type or print)			First OLIVE			Middle PARKER			Last CUMMINGS		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 11-25-91			2a. DATE OF DEATH Month 11 Day 13 Year 68		
7a. BIRTHPLACE (State or foreign country) CONNECTICUT			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			2b. HOUR ^D 1:10 M		
9. COUNTY OF DEATH MONTGOMERY			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		
10. CITY OR TOWN OF DEATH OLNEY			13a. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN SANDY SPRING		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER NORWOOD ROAD			14. FATHER'S NAME First CLARENCE M.			15. MOTHER'S MAIDEN NAME First HARRIET		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. 143-01-2453			17. INFORMANT MEDICAL RECORD DEPT.			Address DICKERMAN		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>										4 hours	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last										years	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED											
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If injury, notify medical examiner)											
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19											
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work											
21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)											
21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 13</u> , 19 <u>68</u> , to <u>Nov 13</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov 13</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>R. A. Yates, M. D.</u>											
22c. DATE SIGNED <u>11/13/68</u>											
22d. PHYSICIAN'S NAME (Type) <u>R. A. YATES, M. D.</u>											
22e. ADDRESS <u>OLNEY, MARYLAND</u>											
23a. CREMATION <input type="checkbox"/> (Specify)											
23b. DATE <u>Nov. 14, 1968</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>Lee Funeral Home</u>											
23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>											
24. FUNERAL DIRECTOR <u>Francis H. Barber Laytonsville Md</u>											
25a. REC'D BY REGISTRAR <u>NOV 18 1968</u>											
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

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16062

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <i>Maphis P Cunningham</i>		2a. DATE OF DEATH Month <i>Nov</i> Day <i>29</i> Year <i>1968</i>		2b HOUR <i>1:30</i> M
3. SEX <i>Male</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>7/28/11</i>	6. AGE (In years last birthday) <i>57</i> YRS	IF UNDER 1 YEAR MONTHS <i>4</i> DAYS <i>1</i>
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i> Md	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Custodian</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>M. C. Schools</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>Mont</i>	13c. CITY OR TOWN <i>Cabin John</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>6523 77th St.</i>
14. FATHER'S NAME First <i>James</i> Middle <i>Eddy</i> Last <i>Cunningham</i>	15. MOTHER'S MAIDEN NAME First <i>Josephine</i> Middle <i>E</i> Last <i>Fletcher</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>No</i> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO. <i>217-26-7216</i>		17 INFORMANT <i>Brother</i> Address <i>Hugh A. Cunningham</i> Same as Item 13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i> <i>1621</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Probable Bronchogenic Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i> <i>Uncertain</i>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1621</i>				
19a. DATE OF OPERATION <i>Oct '68</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Lymph Node Biopsy</i>	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>NO</i>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept</i> , 19 <i>68</i> , to <i>Nov 29</i> , 19 <i>68</i> , that (I) (was) last saw the deceased alive on <i>Nov 28</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.				
22b. SIGNATURE <i>James W. Egan MD</i>	22c. DATE SIGNED <i>11-29-68</i>	22d. PHYSICIAN'S NAME (Type) <i>James W. Egan</i>		
22e. ADDRESS <i>5413 Cedar Lane - Bethesda Md</i>				
23a. BURIAL CREMATION <i>Burial</i>	23b. DATE <i>11-3-68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Warrenton, Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Warrenton Fauquier Va.</i>	
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i> <i>7557-Wisconsin Ave., Bethesda, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 9</i> 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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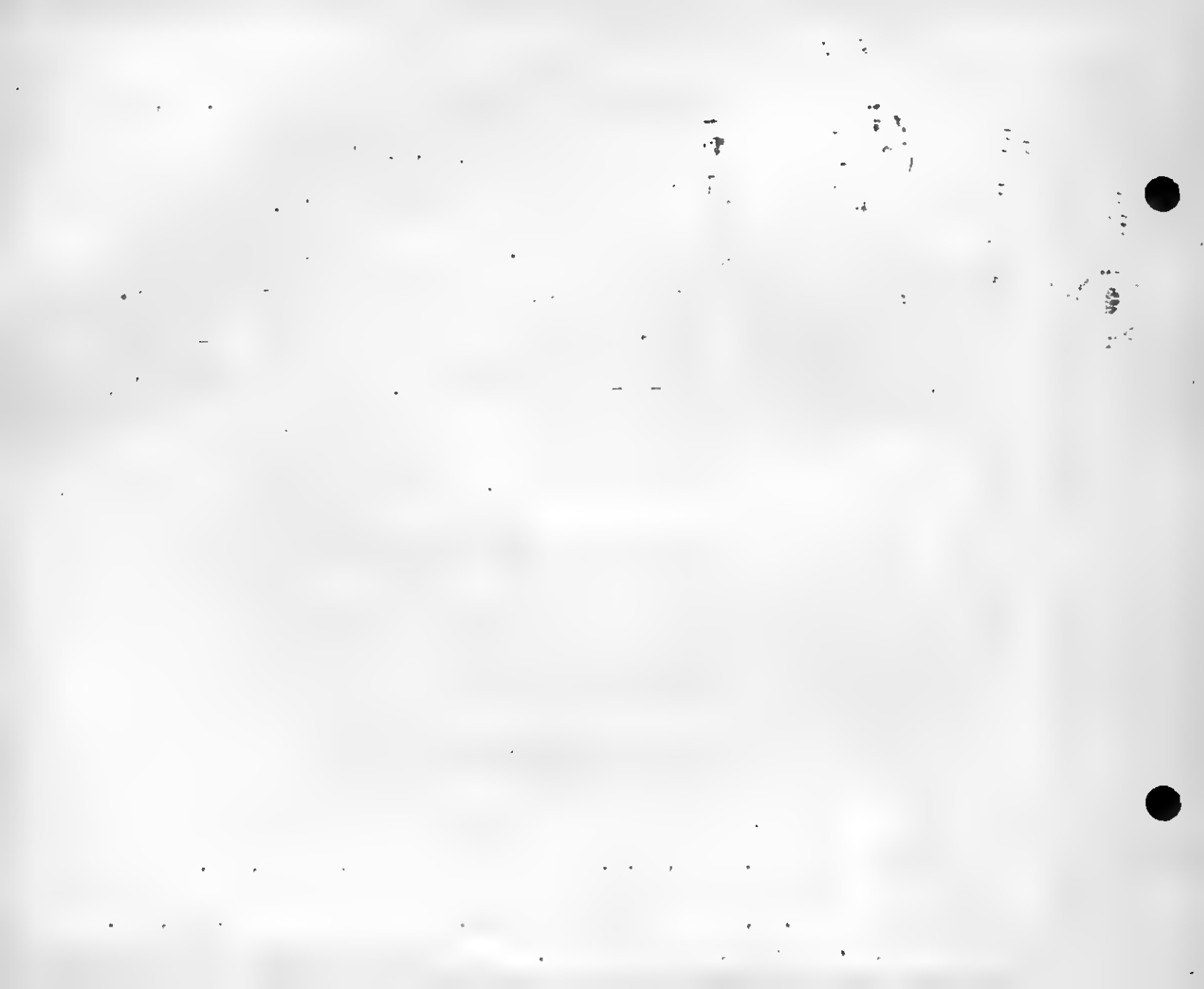
16062

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16070

1 DECEASED-NAME (Type or print) Anna Frances Davis			2a. DATE OF DEATH Month Nov. Day 11 , Year 1968			2b. HOUR 11:30			
3 SEX Female		4 RACE White		5. DATE OF BIRTH May 6, 1911		6 AGE (In years lost birthday) 57 YRS.		7 UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Damascus		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 26609 High St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 26609 High St.	
14. FATHER'S NAME First Middle Last John Edward Brittingham			15. MOTHER'S MAIDEN NAME first Middle Last Nell - Smack						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 215-14-2941		17 INFORMANT Address Clifford J. Davis, 26609 High St. Damascus, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion, myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hour 3 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6/2 , 19 61 , to 11/11 , 19 68 , that (I) (we) last saw the deceased alive on 11/11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James P. Kerr M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/12/68			
22d. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.				22e. ADDRESS Damascus, Md.					
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE Nov. 13, 1968		23c. NAME OF CEMETERY OR CREMATORY Damascus Meth.		23d. LOCATION (City or Town) (County) (State) Damascus, Md.			
24 FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.				25a. REC'D BY REGISTRAR DATE NOV 14 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
45M 1/69

16063		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				1607	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First <u>Annabelle</u> Middle <u>XXXXX</u> Last <u>DAVIS</u>		2a. DATE OF DEATH Month <u>Nov.</u> Day <u>16</u> Year <u>1968</u>		2b. HOUR <u>3 PM.</u>	
3 SEX <u>FEMALE</u>		4 RACE <u>White</u>		5 DATE OF BIRTH <u>Oct. 28, 1879</u>		6 AGE (In years last birthday) <u>89</u> YRS	
7a. BIRTHPLACE (State or foreign country) <u>INDIANA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Montgomery</u>	
10 CITY OR TOWN OF DEATH <u>KENNINGTON MARYLAND</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>KENNINGTON GARDENS NURS. HOME</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>OWNED HOME</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <u>MARYLAND</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>SILVER SPRING</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>9907 MERWOOD LANE</u>		14 FATHER'S NAME First <u>JASPER</u> Middle <u>HENRY</u> Last <u>---</u>		15. MOTHER'S MAIDEN NAME First <u>MARtha</u> Middle <u>---</u> Last <u>BLANKENSHIP</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>NO</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <u>308-46-0722</u>		17 INFORMANT <u>Florence Ireland</u>		Address <u>WATNER PLANK</u> <u>1401 Washington DC</u>	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TOXEMIA + UREMIA</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>---</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u> <u>5 YRS</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>42</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/15</u> , 19 <u>64</u> , to <u>11/16</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/16</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>11/16/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>DR LEO I DUNOVAN</u>				22e. ADDRESS <u>8214 MSC AVE BETH LA</u>			
23a. BURIAL, CREMATION REMOVAL, (Specify)		23b. DATE <u>Nov. 20, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Scottsburg</u>		23d. LOCATION (City or Town) (County) (State) <u>Scottsburg, Indiana</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>				ADDRESS <u>Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 20 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Warner E. Humphrey, Inc. 8434 Ga. Ave. Sil. Spg.</u>				25c. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATE



16064

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16067

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print) First Middle Last GARRY BRAUN DAVIS			2a. DATE KNOWN OF DEATH Month Day Year 11-5 1968		2b. HOUR 4:30 PM
3 SEX MALE	4 RACE White	5 DATE OF BIRTH 8-2-48	6 AGE (In years last birthday) 20 YRS	7c. DATE PRONOUNCED DEAD Month Day Year 11 5 1968	2d. HOUR 4:30 PM
7a. BIRTHPLACE (State or foreign country) California		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery Md.	
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman - Hecht Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.		13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 8714 Bradmore Drive
14 FATHER'S NAME First Middle Last Joseph B. Davis			15 MOTHER'S MAIDEN NAME First Middle Last EVA BRAUN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 217-48-7774		17. INFORMANT Joseph B. Davis ADDRESS Father 8714 Bradmore Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration and maceration, brain</u> DUE TO, OR AS A CONSEQUENCE OF <u>Gunshot wound</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 22 hr
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 6:30 P.M. Nov 4 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Shot self in head with 25 cal Colt	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F. No. City or Town County State 8714 Bradmore Dr. Bethesda Montgomery Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JOHN G. BALL		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 6 Nov. 1968 Bethesda, Md.	
23a. BURIAL CREMATION, REMOVAL, ETC. Cremation		23b. DATE 11-9-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
24. FUNERAL DIRECTOR Robert A Pumphrey Bethesda, Md.		23d. LOCATION (City or Town) (County) (State) Suitland Pr. Geo. Md.		25a. REC'D BY REGISTRAR DATE NOV 13 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

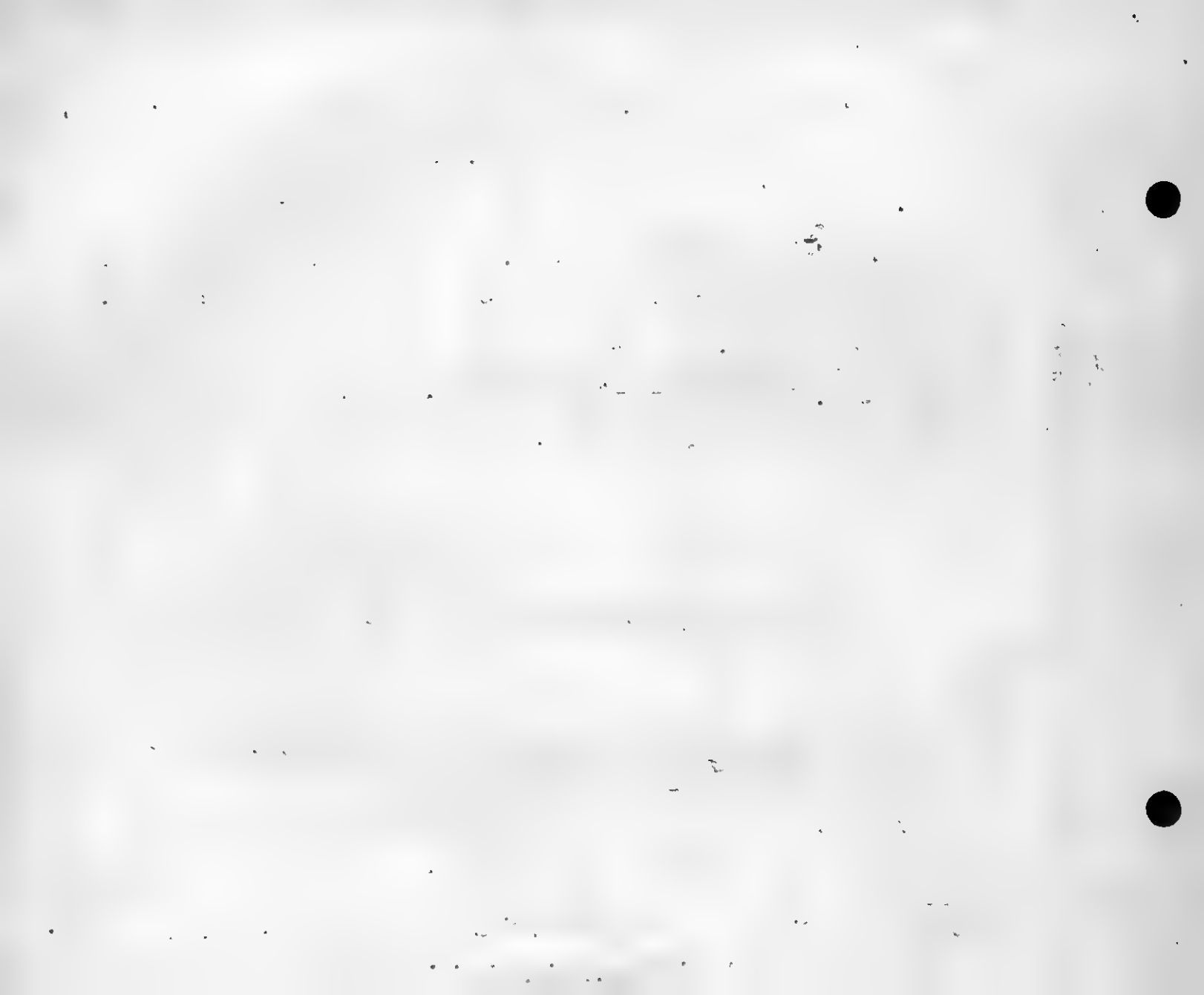
16065

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16079

CERTIFICATE OF DEATH

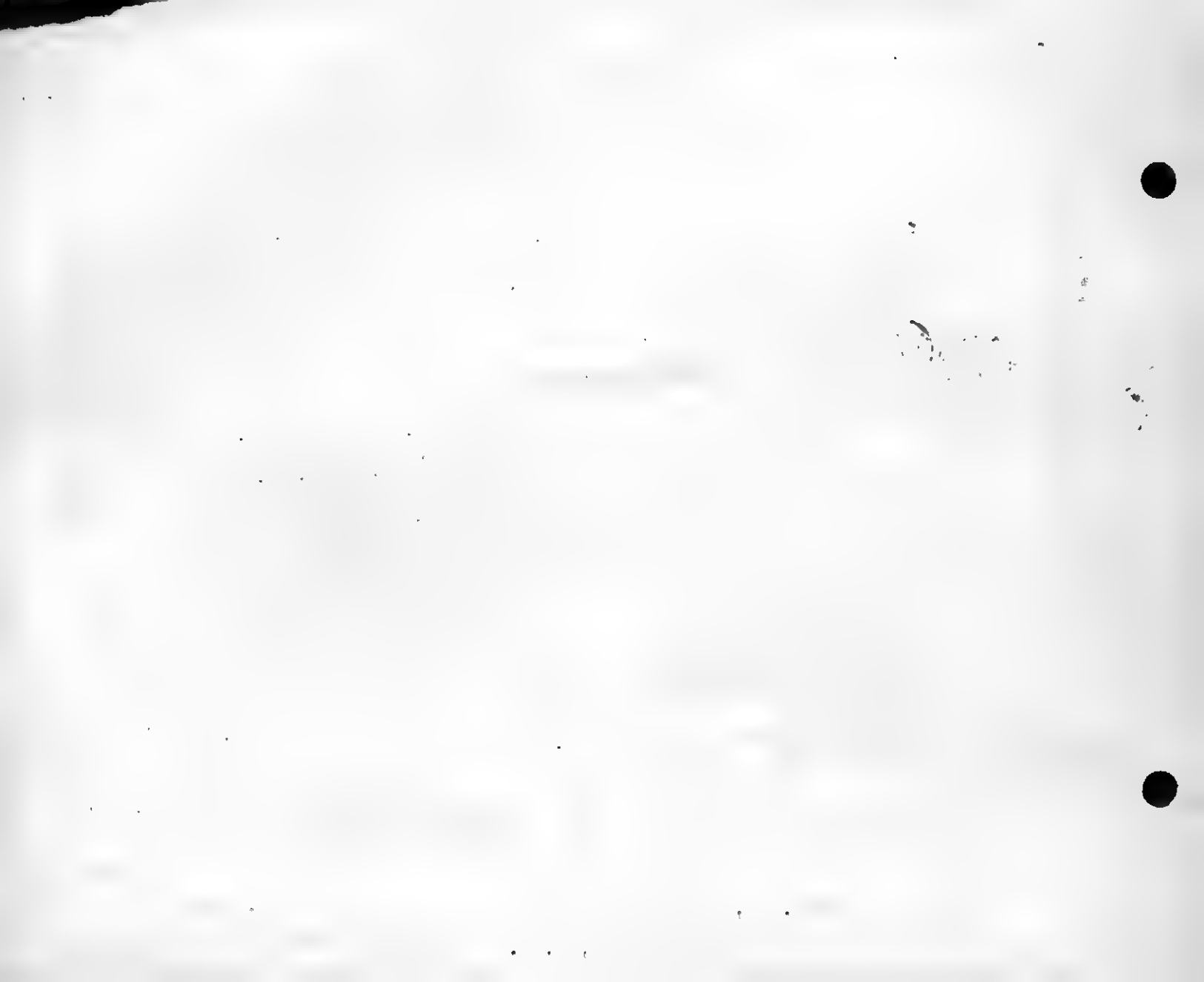
1. DECEASED-NAME (Type or print)		First CORA	Middle S.	Last DAWSON	2a. DATE OF DEATH Nov Month 16 Day 1968		2b. HOUR 5:45 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH Dec. 3, 1875		6. AGE (in years last birthday) 92 YRS.		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Mo.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		Md.	
10. CITY OR TOWN OF DEATH Glen Echo		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6789 Goldsboro Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Glen Echo		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6789 Goldsboro Rd.	
14. FATHER'S NAME George		First L.		Middle Shelton		15. MOTHER'S MAIDEN NAME Anne		First Baily	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO NONE		17. INFORMANT Donald S. Dawson		Address Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>174X Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMATOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>BREAST CARCINOMA</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u> <u>2 YEARS</u> <u>25 YEARS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 1943		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA RT BREAST		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <u>Nov</u> , 1968, to <u>14 NOV</u> , 1968, that (I) (we) last saw the deceased alive on <u>14 NOV</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John C. Sullivan, Sr., M.D.</u> DEGREE ATTENDING <input checked="" type="checkbox"/> MED <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. DIRECTOR PHYS.				22c. DATE SIGNED 16 Nov 1968					
22d. PHYSICIAN'S NAME (Type) <u>John C. Sullivan, Sr., M.D.</u>				22e. ADDRESS 1026 16 St., N.W., Washington, D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11-17-1968		23c. NAME OF CEMETERY OR CREMATORY Eldorado Springs, Missouri		23d. LOCATION (City or Town) (County) (State) Eldorado Springs Mo.			
24. FUNERAL DIRECTOR Joseph Gawlers Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C.				25a. REC'D BY REGISTRAR DATE NOV 22 1968		25b. REGISTRAR'S SIGNATURE <u>William J. Cudde</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR	
Addie Richards Dell						Nov Month 28 Day 68 Year		10 ³⁰ AM	
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR	
Female		white		Jan 10 - 1884		84 YRS		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Dasper, GA		U.S.A.				MONTGOMERY			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USCA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. K NO OF BUSINESS OR INDUSTRY			
Rockville		Potomac Valley N. Home		Housewife					
13a USAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Georgia		Chatham		Savannah				Chatham Apts.	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Faris Carter Richards			MARY			Chapman			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
NO		254-72-0279		Son - Wm B. Dell		208 Gibson St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>Cardiac Decongestion</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>Left Bundle Branch Block</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2 Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>65</u> , to <u>11/28</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
Frank Y. Jagers Jr. MD				<input checked="" type="checkbox"/>				11/28/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
FRANK Y. JAGGERS JR.		5707 WISCONSIN AVE		Bryantwood Ind.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		NOV. 30, 1968		FORREST LAWN		SAVANAH, GEORGIA			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
JOSEPH GAWLER SONS				WASHINGTON, D. C.		DEC 2 1968		Charles Judge	

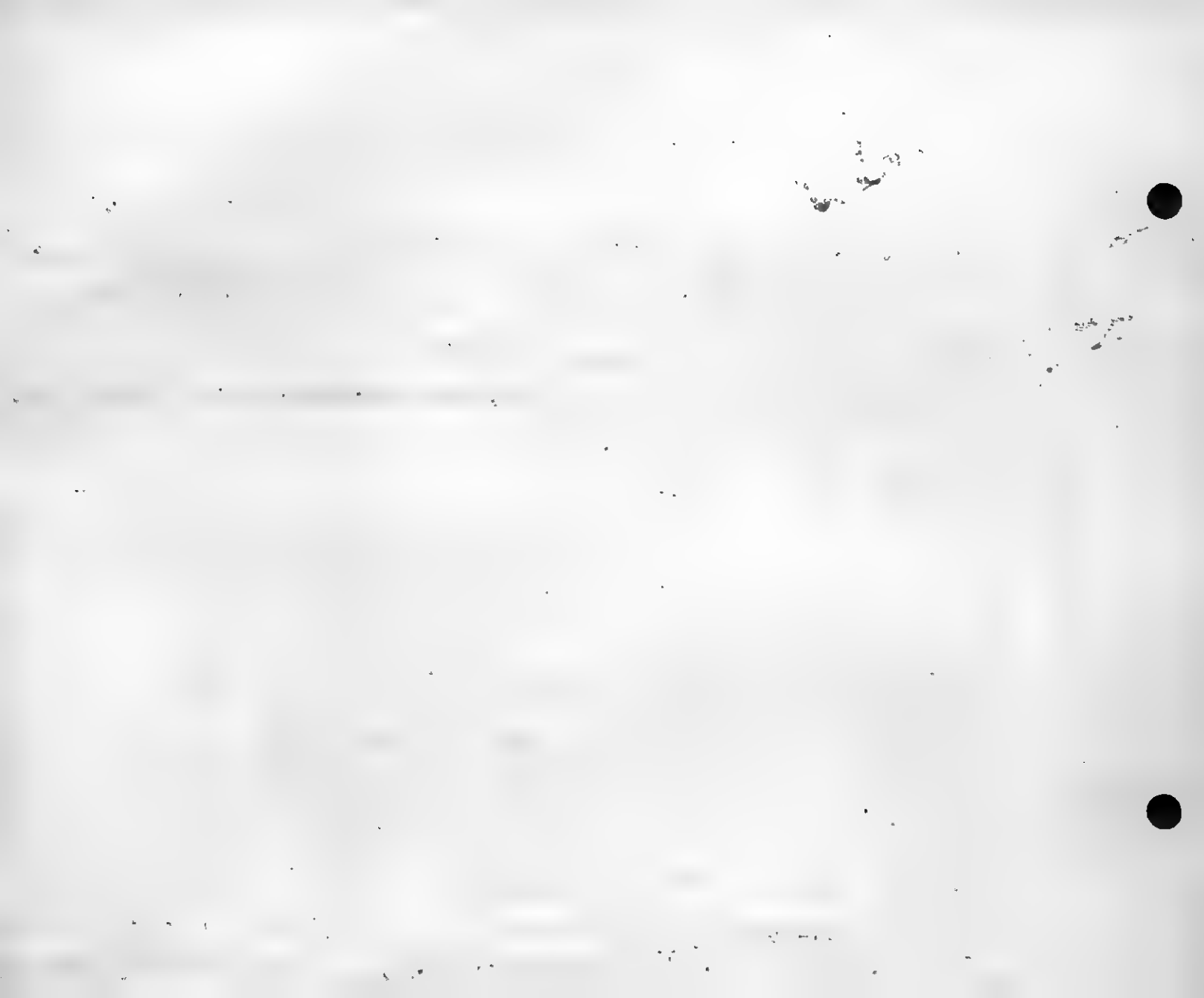


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) <i>Ascenzi NMI De Mattia</i>						2a. DATE OF DEATH Month <i>11</i> - Day <i>23</i> - Year <i>1968</i>			2b. HOUR <i>7:45</i> M		
3 SEX <i>Male</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>May 27, 1984</i>		6 AGE (In years lost birthday) <i>84</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Italy</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery County Md.</i>					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Colonial Villa Nursing Home - 12325 New Hampshire Ave.</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Plaster</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Prince George's</i>		13c. CITY OR TOWN <i>Bowie</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>3507 Mullin Lane</i>			
14 FATHER'S NAME First Middle Last <i>Unknown</i>				15 MOTHER'S MAIDEN NAME First Middle Last <i>Unknown</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give year or dates of service)				16b. SOCIAL SECURITY NO <i>44-1</i>		17 INFORMANT Address <i>Mrs. Tina Pietrzyk 3507 Mullin Lane Bowie Md</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>4/20/7</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>4/20/7</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4/20/7</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2-30 min</i> <i>Years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Laennec's Cirrhosis, Pancreatitis</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>9/12</i> , 19 <i>68</i> , to <i>11/23</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/8</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Marvin Schneider, M.D.</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>11/23/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>MARVIN SCHNEIDER</i>						22e. ADDRESS <i>911 Silver Spring Ave.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11-27-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>		23d. LOCATION (City or Town) (County) (State) <i>Bronx county, N. Y.</i>					
24. FUNERAL DIRECTOR <i>Warner E. Humphrey Inc. 8434 Silver Spring, Md</i>						25a. RECD BY REGISTRAR <i>11/27/68</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION



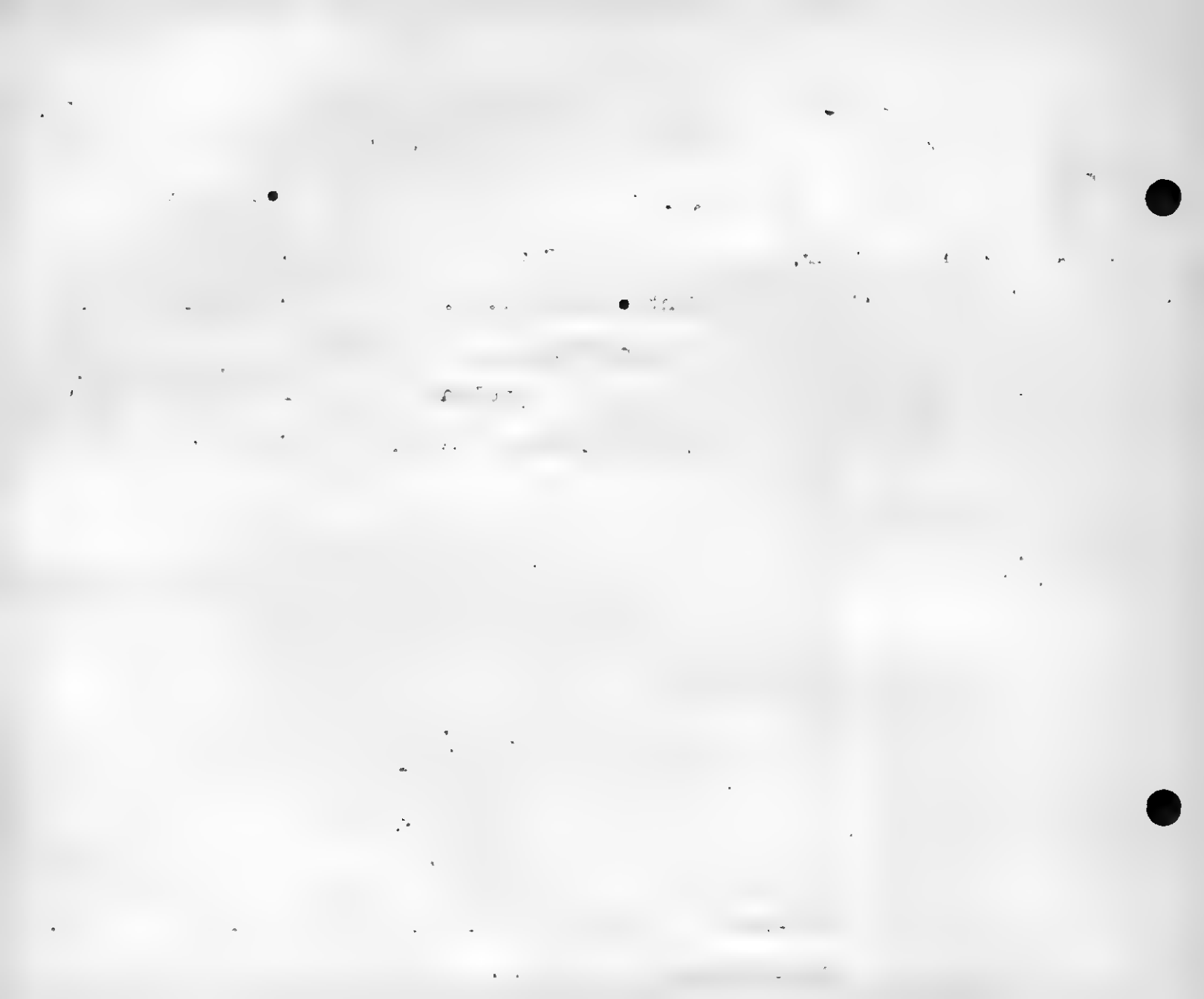
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

Cleared by Dr. Reap

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16068 CERTIFICATE OF DEATH 1603											
1. DECEASED-NAME (Type or print) George Denison						2a. DATE OF DEATH Month 11 Day 4 Year 68			2b. HOUR 2:28 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 12-5-04			6. AGE (In years last birthday) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sales			12b. KIND OF BUSINESS OR INDUSTRY Liquor		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 13012 Georgia Ave.	
14. FATHER'S NAME First Nicholas Middle Last Denison			15. MOTHER'S MAIDEN NAME First Esther Middle Last 								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes, give war or dates of service)				16b. SOCIAL SECURITY NO 		17. INFORMANT Baoline Denison Address Silver Spring, Md. 13012 Georgia Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC. 		21f. LOCATION Street or R.F.D. No. 		City or Town 		County 		State 	
22a. I certify that (I) (this hospital) attended the deceased from December 1968 , to November 1968 , that (I) (we) last saw the deceased alive on October 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Harold W. Draper M.D.						22c. DATE SIGNED 11/4/68					
22d. PHYSICIAN'S NAME (Type) HAROLD W. DRAPER M.D.						22e. ADDRESS 9801 GEORGIA AVE. SILVER SPRING MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-6-1968		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park			23d. LOCATED ON (City or Town) Falls Church (County) (State) Va.				
24. FUNERAL DIRECTOR Goldberg Funeral Home 4217 9th Street N.W.						25a. RECD BY REGISTRAR NOV 6 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last Kathleen Robin Derix						2a. DATE OF DEATH Month Day Year November 15 1968			2b. HOUR AM PM 12:50 AM		
3 SEX Female		4. RACE White		5. DATE OF BIRTH 14 November 1955		6. AGE (in years last birthday) 13 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Pennsylvania		13b. COUNTY ✓		13c. CITY OR TOWN Royersford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 687 North Lewis Road			
14. FATHER'S NAME First Middle Last Calvin Ronald Derix		15. MOTHER'S MAIDEN NAME First Middle Last Helen Elizabeth Wilson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		(If yes give year or dates of service) --		16b. SOCIAL SECURITY NO. None		17. INFORMANT Bethesda, Maryland Address The Medical Records, The Clinical Center.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia with shock 2000 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Granulocytic Leukemia DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days 1 year											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 2042											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9 Sept. , 19 68 , to 15 Nov. , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 15 November 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ira Goldstein		22c. DATE SIGNED 15 November 1968		DEGREE M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>							
22d. PHYSICIAN'S NAME (Type) Ira M. Goldstein, M. D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-18-68		23c. NAME OF CEMETERY OR CREMATORY Morris Cemetery		23d. LOCATION (City or Town) (County) (State) Phoenixville, Penna.					
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		25a. REC'D BY REGISTRAR NOV 20 1968		25b. REGISTRAR'S SIGNATURE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16004

16070

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Horace B Drury		2a DATE OF DEATH Month NOVEMBER Day 17 Year 1968		2b HOURS 3A M
3 SEX M	4 RACE W	5 DATE OF BIRTH AUG 21, 1888	6 AGE (In years last birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Dayton Ohio	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH Rockville	11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) Potomac Valley Nursing Home	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Economist	12b KIND OF BUSINESS OR INDUSTRY	
13a U.S.A. RESIDENCE (Where deceased had abode for 1 year before death) STATE MD	13b. COUNTY MONT	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5520 Western Ave.
14 FATHER'S NAME First Augustus W. Middle Drury Last Drury	15 MOTHER'S MAIDEN NAME First Sophia Middle Backwater Last Backwater			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)	16b SOCIAL SECURITY NO 110	17 INFORMANT Name Robert Drury Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months 2 + yrs.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 332X Parkinson's Disease				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Nov Day 17 Year 1968	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No City or Town County State		
22a I certify that (I) (this hospital) attended the deceased from 11 March 1966 to 12 Nov 1968 , that (I) (not) lost saw the deceased alive on 6 Nov 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE A. H. Richwine MD	DEGREE MD	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22. DATE SIGNED 12 Nov 1968	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS 5522 Western Ave Cherry Chase, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 11-12-68	23c. NAME OF CEMETERY OR CREMATORY Bee's Crematory	23d. LOCATION (City or Town)	(County) (State)
24. FUNERAL DIRECTOR LEE FUNERAL HOME		ADDRESS 3014 ST. NE	25a. REC'D BY REGISTRAR NOV 15 1968	25b. REGISTRAR'S SIGNATURE Charles Judge



2



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 7-243. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16071

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16085

1 DECEASED NAME (Type or Print) <i>George William Jeffers</i>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <i>Nov.</i> Day <i>9</i> Year <i>1968</i>			2b. HOUR <i>4:30</i> M <i>PM</i>		
3 SEX <i>male</i>	4 RACE <i>negro</i>	5 DATE OF BIRTH <i>5/18/1872</i>	6 AGE (In years last birthday) <i>96</i> YRS.	IF UNDER 1 YEAR MONTHS <i>1</i> DAYS <i>1</i>	IF UNDER 24 HRS HOURS <i>1</i> MIN. <i>1</i>	2c. DATE PRONOUNCED DEAD Month <i>Nov.</i> Day <i>9</i> Year <i>1968</i>		
7a. BIRTHPLACE (State or foreign country) <i>md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md		
10 CITY OR TOWN OF DEATH <i>Rockville</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban Labor or</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY <i>private</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>118 N. Street</i>
14 FATHER'S NAME First <i>Henry</i> Middle <i>Jeffers</i> Last <i>Jeffers</i>			15 MOTHER'S MAIDEN NAME First <i>Unknown</i> Middle <i></i> Last <i></i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16b. SOCIAL SECURITY NO <i>md.</i>			17. INFORMANT <i>Mabel Jackson</i> ADDRESS <i>Same as above</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Thrombosis</i>								<i>2 weeks -</i>
4 DUE TO, OR AS A CONSEQUENCE OF								<i>years</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) <i>Generalized arterio sclerosis</i>								
DUE TO, OR AS A CONSEQUENCE OF								
(c) <i></i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4500</i>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John W. Ball</i> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>Nov-10, 1968</i>		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>11-15-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Park Cem</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville Montg Md.</i>		
24. FUNERAL DIRECTOR <i>Robert L. Snowden</i> ADDRESS <i>Rockville Md.</i>				25a. REC'D BY REGISTRAR <i>NOV 15 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

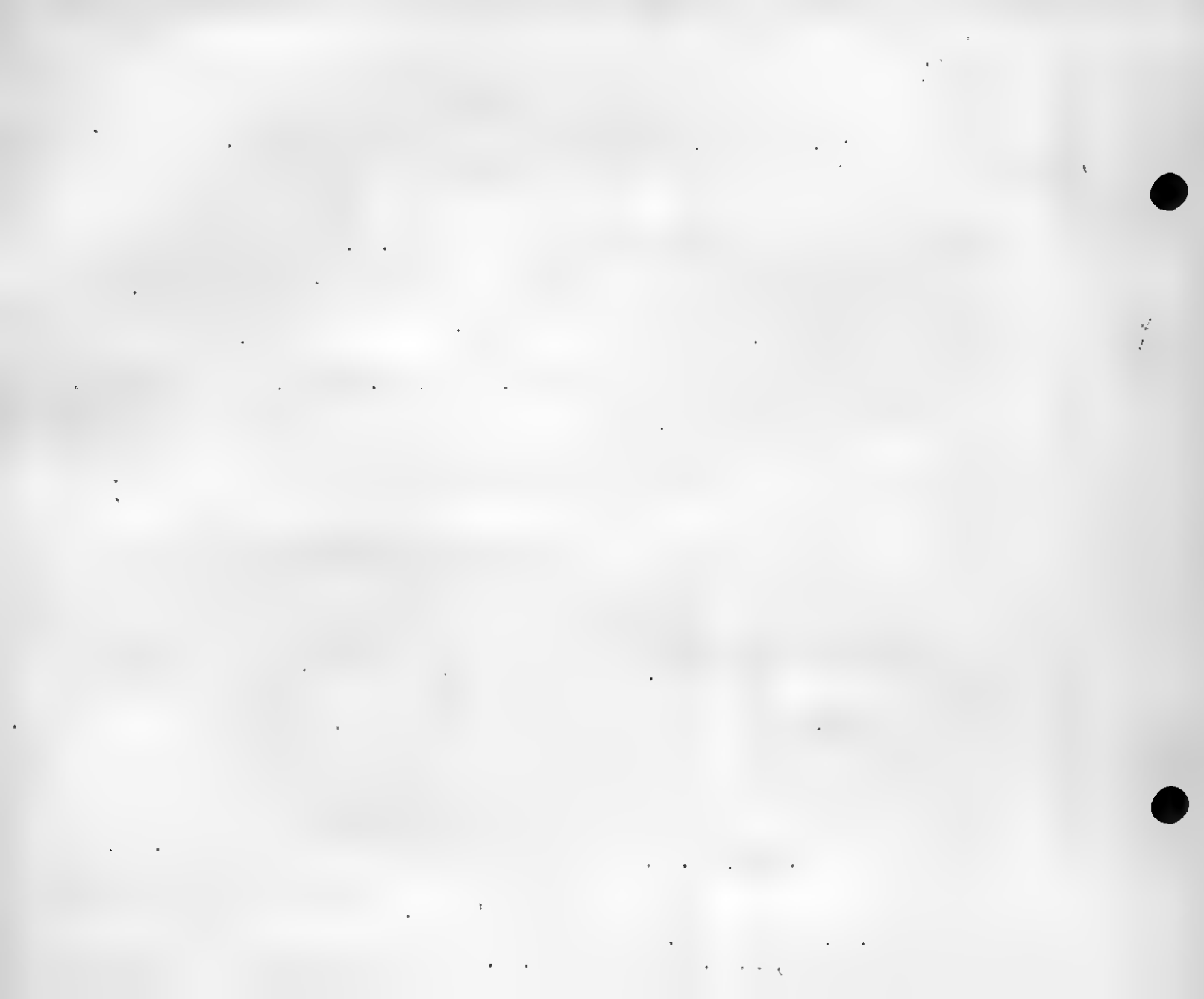
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16072											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Frank		Middle Aloysius		Last Duffy		2a. DATE OF DEATH Month 2 Day 1968 Year		
3 SEX Male		4 RACE Cauc.		5. DATE OF BIRTH 12/9/1907			6 AGE (In years last birthday) 57 YRS.		2b HOUR 1 1/2 M		
7a BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Wheaton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Accountant			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b COUNTY Prince Georges		13c CITY OR TOWN Beltsville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1103 Greenmount Avenue		
14. FATHER'S NAME First James Middle Last			15. MOTHER'S MAIDEN NAME First Margaret Middle Last			Address Josephine Kearney					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO			17 INFORMANT MRS RUTH A. DUFFY (SAME AS 13e)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH CAUSED BY IMMEDIATE CAUSE (a) Metastatic Brain Lesions, Multiple DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause 1991 Concussion DUE TO, OR AS A CONSEQUENCE OF 1st not found during Hospital stay APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 9 mos 6 mos											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerosis Heart Disease											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Aug, 1968, to Nov, 1968, that (I) (we) last saw the deceased alive on 31 Oct 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Merton L. White M.D.		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 2 Nov 68					
22d PHYSICIAN'S NAME (Type) MERTON L. WHITE		22e ADDRESS 9911 Georgia Ave Silver Spg, Md									
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE Nov 5, 1968		23c NAME OF CEMETERY OR CREMATORY Mount Carmel Cemetery		23d LOCATION (City or Town) Washington		(County)		(State) D.C.	
24. FUNERAL DIRECTOR Charles Judge		ADDRESS 754 Carroll St NW		25a REC'D BY REGISTRAR DATE NOV 6 1968		25b REGISTRAR'S SIGNATURE Charles Judge					

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Richard James DUGGAN						Month Day Year		8:45 AM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 24 HRS MONTHS	8 UNDER 24 HRS DAYS	9 UNDER 24 HRS HOURS	10 UNDER 24 HRS MIN	2c. DATE PRONOUNCED DEAD	
Male	Cauc.	May 19, 1930	38 YRS					Month Nov. Day 16 Year 68	
7a. BIRTHPLACE (State or country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR	
Illinois Lanesville		USA				Montgomery		8:45 AM	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			Naval Hospital			U. S. Air Force		Armed Forces	
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Virginia			Hampton					13e. STREET AND NUMBER	
								328 Whealton Rd. Hampton, Va.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Eugene F. Duggan			Annie Mulcahy						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
yes			325 24 2185			Mrs. Frances A. Duggan, 328 Whealton Rd. Hampton, Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Peritonitis									5 days
DUE TO, OR AS A CONSEQUENCE OF (b) Gunshot wound of abdomen									7 days
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
			3:20 PM Nov. 9 1968			Shot self in abdomen with shotgun			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		21g. City or Town	
home						328 Whealton Rd.		Hampton Va.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
John G. Ball			John G. Ball, M. D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Nov. 18, 1968	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		23e. (County) (State)	
Burial		Nov 23, 1968		Camp Butler Nat'l Cem.		Springfield		Illinois	
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
1400 Chapin Street, N. W. Washington, D. C.						DATE NOV 26 1968		J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: This low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in the funeral director's office. After the funeral, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them in the funeral director's office. The certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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16074

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16088

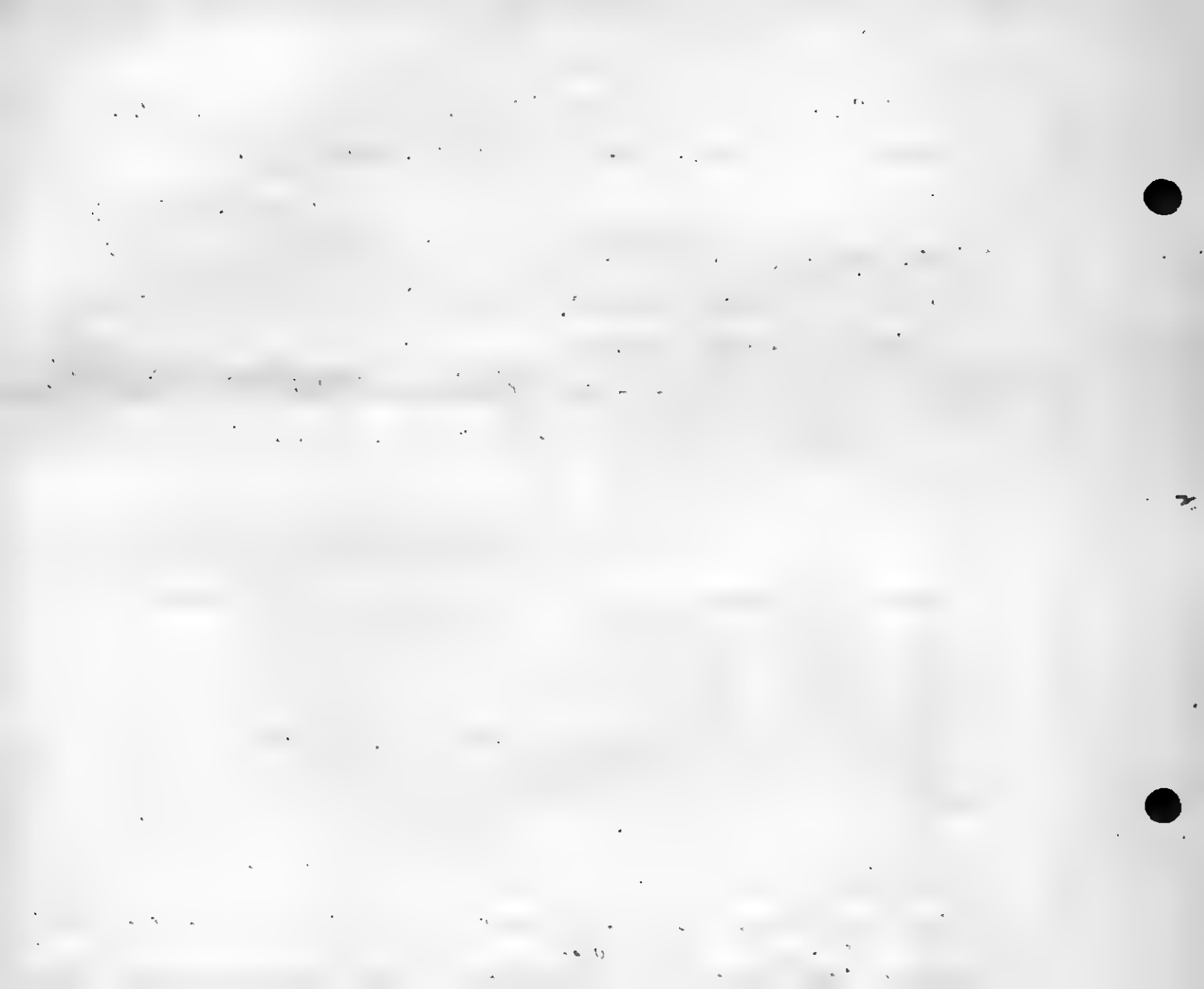
1 DECEASED NAME (Type or print) Robin Leigh Elliott			2a. DATE OF DEATH Month November Day 6 Year 1968			2b. HOUR a 12:45 MIN. M								
3 SEX Female		4 RACE White		5. DATE OF BIRTH 10-30-68		6 AGE (In years last birthday) 8 YRS		IF UNDER 1 YEAR MONTHS 8 DAYS		IF UNDER 24 HRS. HOURS 8 MIN.				
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery			Md					
10 CITY OR TOWN OF DEATH Takoma Park			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None			12b KIND OF BUSINESS OR INDUSTRY None					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b COUNTY Montgomery			13c CITY OR TOWN Takoma Park			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 8302 Garland Ave.,		
14 FATHER'S NAME First Stephen Middle Gary Last Travis			15 MOTHER'S MAIDEN NAME First Barbara Middle Jo Last Elliott											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No			16b SOCIAL SECURITY NO.			17 INFORMANT Barbara Elliott			Address Takoma Park, Maryland					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory cessation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Brain Damage DUE TO, OR AS A CONSEQUENCE OF (c) Anoxia at birth											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Oct 30, 1968 , to Nov 6, 1968 , that (I) (we) last saw the deceased alive on Nov 6, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death														
22b. SIGNATURE [Signature]			DEGREE MD			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED Nov 6 1968					
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) Creation			23b. DATE 11-6-68			23c. NAME OF CEMETERY OR CREMATORY Washington San & Hospital			23d. LOCATION (City or Town) (County) (State) Takoma Park Mont., Md.					
24. FUNERAL DIRECTOR J.D. Ruffcorn						ADDRESS 7600 Carroll Ave., Tk.Pk. Md.			25a. REC'D BY REGISTRAR NOV 8 1968			25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) VIRGINIA Stewart ERSKINE					2a. DATE OF DEATH Month Nov. Day 15 Year 1968			2b. HOUR 5 A-M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MAR 30 1982		6 AGE (in years lost birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (State or foreign country) OHIO		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.			
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Althea Woodland Mission		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Missionary		12b. KIND OF BUSINESS OR INDUSTRY Mission			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. CITY OR TOWN Primer George Hyattsville		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6519 Medwick Dr.			
14 FATHER'S NAME First John Middle Thomas Last Stewart			15. MOTHER'S MAIDEN NAME First Ruth Middle Williams Last Williams						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 219-54-9495		17. INFORMANT Ruth Erskine Address same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) SENILITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July , 19 64 , to Nov 15 , 19 68 , that (I) (we) lost saw the deceased alive on Nov 14 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Bernard A. Fitzgerald MD DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11-15-68			
22d. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD				22e. ADDRESS 217 UNIV BLVD, SILVER SPRING, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 18, 1968		23c. NAME OF CEMETERY OR CREMATORY Geo. Washington Cemetery		23d. LOCATION (City or Town) (County) (State) Adelphi Pr. Geo. Maryland			
24. FUNERAL DIRECTOR Warner E. Pumphrey Inc. ADDRESS 8434 Ga. Ave. S.S. Md.				25a. RECD BY REGISTRAR NOV 20 1968 DATE		25b. REGISTRAR'S SIGNATURE William J. O'Keefe			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 10 days after death.

Approved by Medical Examiner

MIDDLE NAME		FIRST NAME		CERTIFICATE OF DEATH	
1. DECEASED-NAME (Type or print)		2a. DATE OF DEATH		2b. HOUR	
XXXX Stephen Halstead Farrell		Nov. 13 1968		8:45 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	
M.	W. White	Aug 14 - 1896	72 YRS.	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
Ky.	U.S.A.		Montgomery Md		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda	Suburban	Retired	Food Products		
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before death) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
Maryland	Montgomery	Rockville		10500 Rockville Pike	
14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give date of service)			
Benjamin A. Farrell	Mayme L. Smith	16b. SOCIAL SECURITY NO.			
17. INFORMANT	Address				
W. E. Minnihan	Elizabeth L. Daly 4425 Waltham Place N.W. D.C.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) 1896 Pulmonary embolism sup.					
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the Kidney sup.					
DUE TO, OR AS A CONSEQUENCE OF (c) 3 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
1. None					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from June 1961 to November 1968, that (I) (we) last saw the deceased alive on November 13 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE	22c. DATE SIGNED	22d. PHYSICIAN'S NAME (Type)			
Ralph F. Patten	11/13/68	RALPH F. PATTEN M.D. 407 Woodside Parkway Silver Spring Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)		
Burial	11-16-1968	Gate of Heaven Cemetery	Silver Spring, Mont. Co., Md		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016		DATE NOV 18 1968			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 407 Maryland State Department of Health
11-29-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16091

16077

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) First Middle Last Juanita Taylor Fentress			2a. DATE KNOWN OF DEATH ESTIMATED Month Day Year 11 14 1968			2b. HOUR 9:55	
3 SEX Female	4 RACE White	5 DATE OF BIRTH 11/4/28	6 AGE (In years) 40 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year 11 14 1968		2d. HOUR 10:PM
7a. BIRTHPLACE (State or foreign country) Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH en route to hospital		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp't give street address) Montgomery General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Clarksburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Box 96		14. FATHER'S NAME First Middle Last George Washington Taylor		15. MOTHER'S MAIDEN NAME First Middle Last Alice Ruth Curry			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT Records ADDRESS Montgomery General Hospital, Olney, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion with DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial infarction; DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery heart disease							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Eldon R. Reed, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED Nov 15, 1968	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/18/68		23c. NAME OF CEMETERY OR CREMATORY Germantown		23d. LOCATION (City or Town) (County) (State) Germantown, Montg. Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home 1331 Rock Pike ROCK HILL, MD.				25a. RECD BY REGISTRAR DATE NOV 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

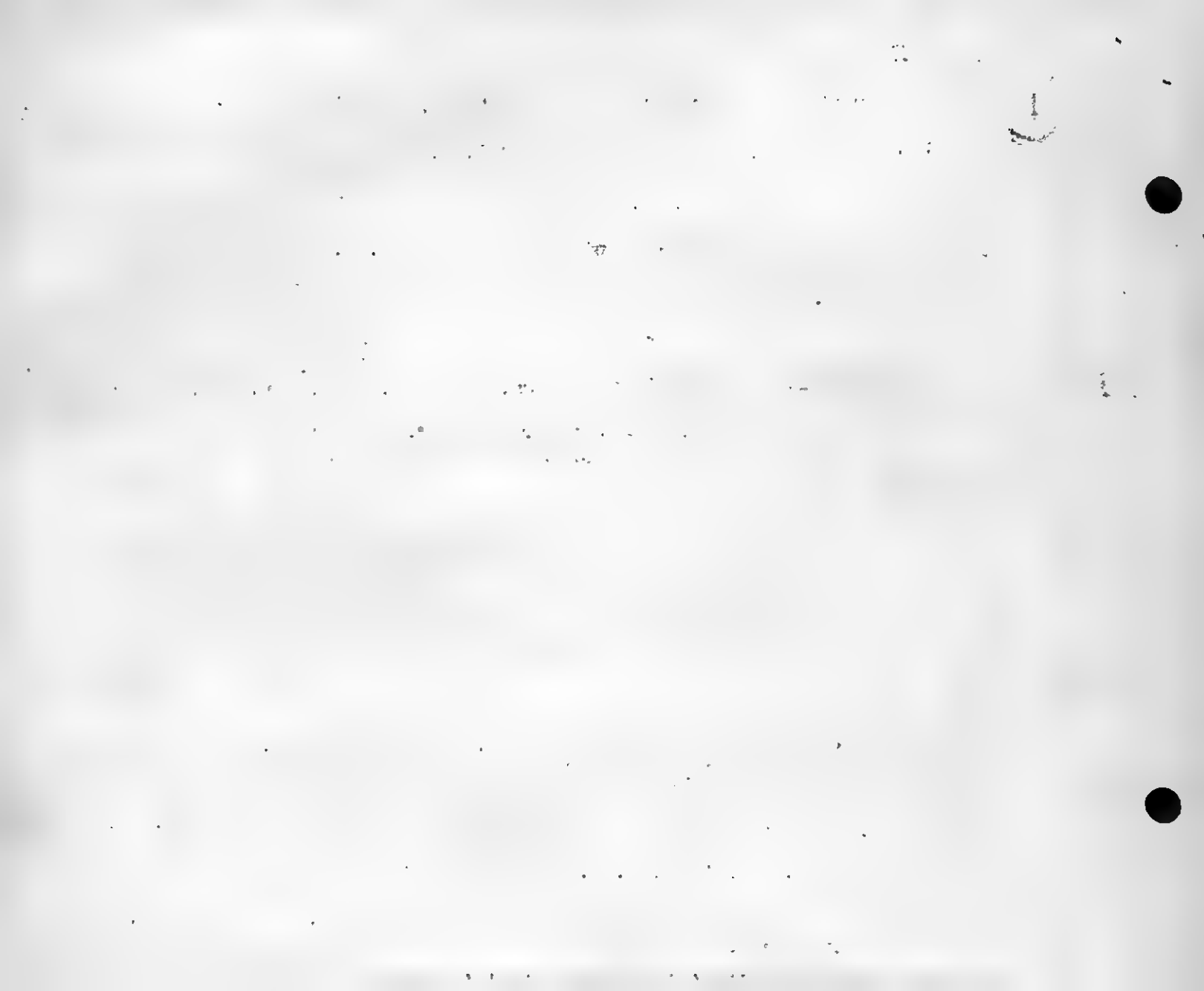
16078

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16002

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Beauford Wallace FINK Jr.			2a. DATE OF DEATH Month November Day 12 Year 68			2b. HOUR 915A M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH Jul. 31, 1900		6. AGE (In years last birthday) 68 YRS.	
7a. BIRTHPLACE (State or foreign country) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U. S. Navy		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 8315 North Brook Lane							
14. FATHER'S NAME First Middle Last Beauford Wallace Fink			15. MOTHER'S MAIDEN NAME First Middle Last Jessie Harris				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO 1922-49 230 48 9019		17. INFORMANT 8315 North Brook Lane Bethesda, Md. Mrs. Idella D. FINK, Apt. 206, Whitehall West			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe coronary atherosclerosis with occlusion of the left coronary ostia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that He (this hospital) attended the deceased from Oct. 11, 1968 , to Nov. 12, 1968 , that He (we) lost saw the deceased alive on Nov. 12, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, He (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jack C. Zimmerman M.D.				22c. DATE SIGNED Nov. 13, 1968		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-15-1968		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Va.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Joseph Gawler & Sons				25a. REC'D BY REGISTRAR DATE NOV 13 1968		25b. REGISTRAR'S SIGNATURE Joseph Gawler	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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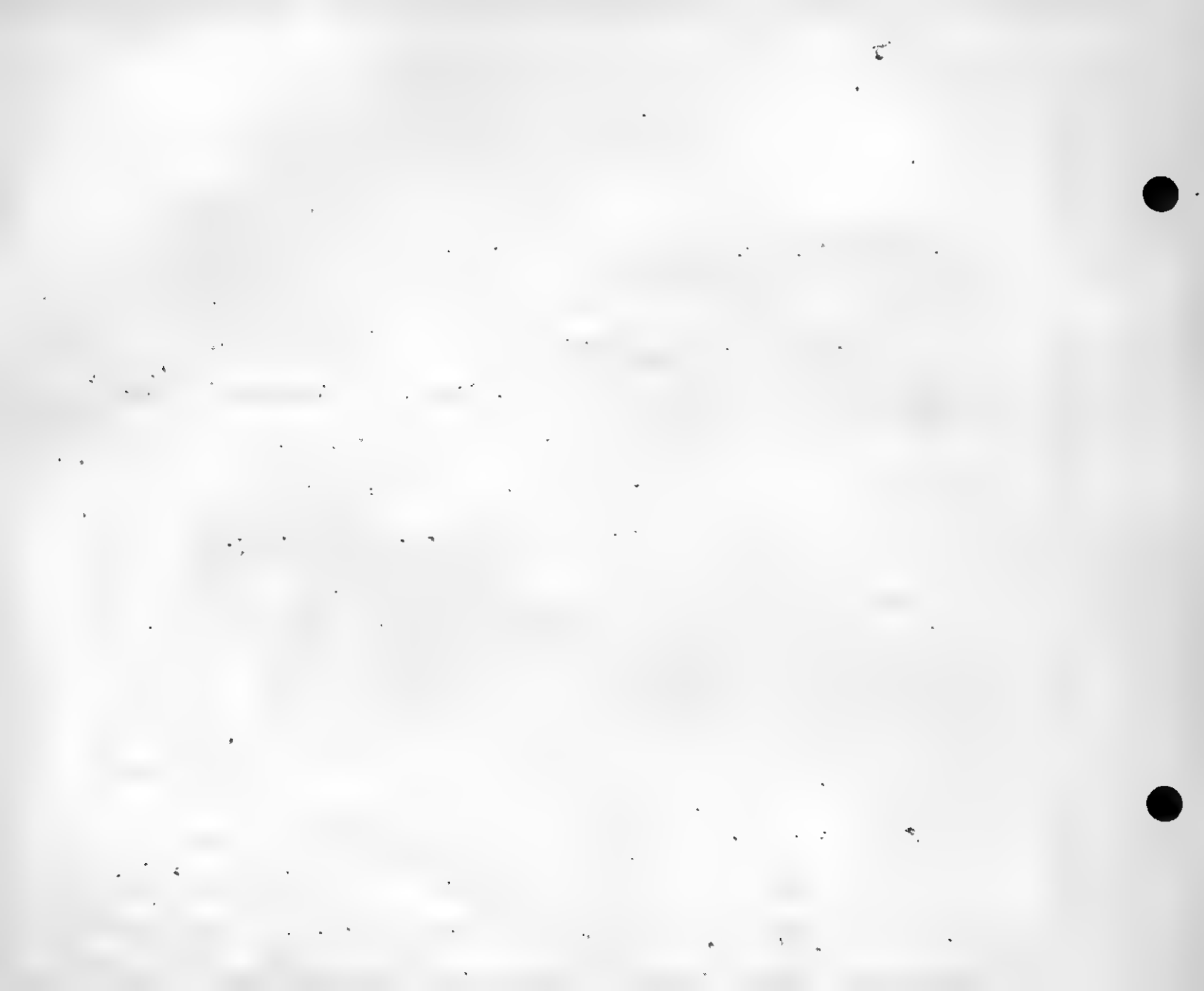
15079

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16093

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Thomas M. Flanagan			2a. DATE OF DEATH Month 11 Day 23 Year 68			2b. HOUR 9:20 a.m.	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH 10/24/14		6 AGE (in years last birthday) 54 YRS.	
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Economist		12b. KIND OF BUSINESS OR INDUSTRY Gov't.	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spg.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 555 Thayer Ave.		14. FATHER'S NAME First Timothy Middle J. Last Flanagan		15. MOTHER'S MAIDEN NAME First Mary Middle J. Last Madden		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No	
16b. SOCIAL SECURITY NO. 217-09-5858		17 INFORMANT Mrs. Mary Louise Flanagan		Address Sil. Spr., Md.		Address 555 Thayer Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) SUBARACHNOID HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (c) RUPTURED CEREBRAL ANEURYSM							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 6 days 6 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None							
19a. DATE OF OPERATION 11/26/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED RESPIRATORY-TRACHEOTOMY		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11/17 , 19 68 , to 11/23 , 19 68 , that (I) (we) last saw the deceased alive on 11/22 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Francis C. Mayle				22c. DATE SIGNED 11/23/68		22d. PHYSICIAN'S NAME (Type) FRANCIS C. MAYLE	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 11-26-1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Sil. Spr. Montgomery Md.	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		Address Sil. Spr. Md.		25a. REC'D BY REGISTRAR NOV 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16080

16094

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) James Edwin Fleener			2a DATE OF DEATH Month 11 Day 25 Year 68			2b HOUR 7:20 PM					
3 SEX MALE		4 RACE White		5 DATE OF BIRTH 12-30-04		6 AGE (In years last birthday) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (State or foreign country) IOWA		7b CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10 CITY OR TOWN OF DEATH Bethesda			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Suburban			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Retired			12b KIND OF BUSINESS OR INDUSTRY FOREIGN SERVICE		
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE D.C.			13b COUNTY Washington			13c CITY OR TOWN Washington			13d INSIDE CITY LIM IT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER 5812 Chevy Chase Parkway			14. FATHER'S NAME First Middle Last JAMES EVAN FLEENER			15. MOTHER'S MAIDEN NAME First Middle Last ALICE HAGAN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)			16b SOCIAL SECURITY NO -			17 INFORMANT MARGUERITE BURDA FLEENER, WIFE, SAME AS			Address ITEM #13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hepatic insufficiency 11/27 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic melanoma DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1900											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11-20, 1968 , to 11-25 , 19 68 , that (I) (we) last saw the deceased alive on 11-25 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE James P. McCarrick DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>									22c DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) JAMES P. MCCARRICK						22e ADDRESS 809 Cherry Mill Rd Rockville Md					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 11-29-1968			23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery			23d LOCATION (City or Town) (County) (State) Silver Spring, Montgomery Co. Md.		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016						25a RECD BY REGISTRAR NOV 29 1968			25b REGISTRAR'S SIGNATURE Charles Judge		

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16081

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16085

1. DECEASED-NAME (Type or print) Charles R Fleming			2a. DATE OF DEATH Month 11 Day 29 Year 1968			2b. HOUR 12:45 M		
3. SEX male		4. RACE white		5. DATE OF BIRTH 2/8/30		6. AGE (In years last birthday) 38 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County Md.		
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hop Cross Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 509 Calvin Lane			12b. KIND OF BUSINESS OR INDUSTRY					
14. FATHER'S NAME First Middle Last Arthur Fleming			15. MOTHER'S MAIDEN NAME First Middle Last Lola Haines Gates					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) Yes Korean			16b. SOCIAL SECURITY NO. 215-24-3699		17. INFORMANT Wife Jacqueline L. Fleming Address Same as Item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Brain Disease 1720 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Melanoma, Left eye DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few wks 2 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from OCT 1968 , to NOV 29, 1968 , that (I) (we) lost saw the deceased alive on 11/28/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE G. Leonard Gold DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 11/29/68				
22d. PHYSICIAN'S NAME (Type) G. LEONARD GOLD				22e. ADDRESS 9801 Georgia Ave. Silver Spring, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-3-68		23c. NAME OF CEMETERY OR CREMATORY Baltimore Natl Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR DEC 9 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

MEDICAL CERTIFICATION

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16082		16094									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																					
1. DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR				
Nathaniel							Floyd		ESTIMATED		Nov		11		1968		11:15 A.M.				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month		Day		Year		2d. HOUR	
M.		Negro		Not known		55 YRS		MONTHS		DAYS		Nov		11		1968		11:15 A.M.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH												
Not known			USA			Not known			Montgomery												
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY									
Bethesda				Suburban				Laborer				Handyman									
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET AND NUMBER					
D.C.								Washington				YES <input type="checkbox"/> NO <input type="checkbox"/>				1343 V Street N.W.					
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				First		Middle		Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1. DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) Coronary Insufficiency Acute										Sudden											
4131 DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																					
(b) Hypertensive Cardio Vascular Disease										years.											
DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																					
MEDICAL CERTIFICATION																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
				HOUR A.M. P.M. 19																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No				City or Town		County		State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE				John B. Ball				M.D.				22b. DATE SIGNED				Nov 11, 1968					
EXAMINER'S NAME (Type)								CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
																ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)				(County)		(State)			
				11/21/1968				The Anatomy Bd. of Md.													
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
								DATE NOV 4 3 1968				James L. Jones									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16083

16097

1. DECEASED NAME (Type or print) Kenneth Allison Fones			2a. DATE OF DEATH Month November Day 25 Year 1968			2b. HOUR 1:05 M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH 12 July 1929		6 AGE (in years last birthday) 39 YRS	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Manager		12b. KIND OF BUSINESS OR INDUSTRY Used Car Sales	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Virginia		13b. COUNTY Fairfax		13c. CITY OR TOWN Alexandria		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 6219 Driftwood Drive		14. FATHER'S NAME First Sam Middle Fones Last Fones		15. MOTHER'S MAIDEN NAME First Margaret Middle Zellar Last Zellar			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 1950-1951		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant melanoma with widespread metastases 1747 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1904 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Segmental pneumonia, left lung							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-1/2 yrs.
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that XX (this hospital) attended the deceased from Oct. 14 , 19 68 , to Nov. 25 , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on November 25 , 19 68 , and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) XXXX view the body after death.							
22b. SIGNATURE Peter J. Rosen M.D.				22c. DATE SIGNED 25 November 1968			
22d. PHYSICIAN'S NAME (Type) Peter J. Rosen, M.D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/29/68		23c. NAME OF CEMETERY OR CREMATORY Calvary Memorial		23d. LOCATION (City or Town) (County) (State) Fairfax, Virginia	
24. FUNERAL DIRECTOR Arnold E. Burner Cunningham Funeral Home, Inc.				25a. REC'D BY REGISTRAR DATE NOV 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
16084 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print) <i>Robert Foster</i>			First <i>Robert</i> Middle <i>Ethyl</i> Last <i>Foster</i>			2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> <i>Nov 5, 1968</i>		2b HOUR <i>2:30 PM</i>		
3. SEX <i>MALE</i>		4 RACE <i>WHITE</i>		5 DATE OF BIRTH <i>11-20-14</i>		6 AGE (In years last birthday) <i>53</i> YRS		2c DATE PRONOUNCED DEAD Month <i>Nov</i> Day <i>5</i> Year <i>1968</i>		
7a BIRTHPLACE (State or foreign country) <i>Arkansas</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>		Md		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>8019 Eastern Ave. Specialist</i>			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>Specialist</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Aviation Agency</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Silver Spring</i>		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <i>8019 Eastern Ave.</i>	
14 FATHER'S NAME First <i>Luther</i> Middle <i>Foster</i> Last <i>Foster</i>			15 MOTHER'S MAIDEN NAME First <i>Andie</i> Middle <i>Bird</i> Last <i>Bird</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO <i>444-01-4592</i>		17 INFORMANT <i>Pauline Foster</i> ADDRESS <i>wife-S.S. Md. Silver Spring, Police 8019 Eastern Ave</i>					
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonia. Lobular. Bilateral/Extensive.</i> <i>4122</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Years</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4222</i>										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>John G. Ball</i>			EXAMINER'S NAME (Type) <i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <i>Nov-6, 1968</i>	
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
						ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>11-10-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holdenville Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Holdenville, Oklahoma</i>		
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>			ADDRESS <i>Sil. Spr. Md.</i>			25a. REC'D BY REGISTRAR <i>NOV 12 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18a, 2a, 407 MARYLAND STATE DEPARTMENT OF HEALTH
1-27-68ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16090

16085

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		Month		Day		Year		2b HOUR	
CALVIN THOMAS FOSTER, SR.								11-14-68		11		14		68		8:05pm	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month		Day		Year	
Male	White	8-14-08		60 YRS		MONTHS		DAYS		11		14		68		8:05pm	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH											
Ohio		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery										Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during past of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY											
Takoma Park		Wash. San. & Hosp.		Packer		Security Storage											
13a USUAL RESIDENCE (Where deceased lived, if institution Res. den. before adm. ssion) STATE		13b. COUNTY		13c CITY OR TOWN		3d. INSIDE CITY LIMITS?		13e STREET AND NUMBER									
Md.		Mont.		S.S.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9120 Flower Ave.									
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last			
James G. Foster								Ella Mae Campbell									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS									
No				573-07-4129		Calvin Foster, Jr. Son		9120 Flower Ave. Silver Spring, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary insufficiency																	
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a DATE OF OPERATION																	
19b CONDITION FOR WHICH OPERATION WAS PERFORMED?																	
20 ALTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
				HOUR A.M. P.M. 19													
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No				City or Town					
												County					
												State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED									
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>													
BELDEN R. REAP M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>													
				ADDRESS (Street, City or Town, County)													
23a BURIAL, CREMATION REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)					
Burial				Nov. 19, 1968				Parklawn Cemetery				Rockville, Maryland					
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE					
Warner & Pumphrey, Inc.				8434 Ga. Ave. Sil. Spg. Md.				NO. 20 1968									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16086

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16100

1 DECEASED NAME (Type or print) First Middle Last Ralph Franklin Fox			2a DATE OF DEATH Month Day Year November 28, 1968		2b HOUR 12:38
3 SEX Male	4 RACE White	5. DATE OF BIRTH December 4, 1888		6 AGE (In years lost birthday) 79 YRS	
7a BIRTHPLACE (State or foreign country) Ohio	7b CITIZEN OF WHAT COUNTRY? America	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery Md.		
10 CITY OR TOWN OF DEATH Takoma Park	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machine Worker		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b COUNTY Prince George	13c CITY OR TOWN Hyattsville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 2007 Hannon Street	
14. FATHER'S NAME First Middle Last Charles Fox			15. MOTHER'S MAIDEN NAME First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) yes		(If yes give war or dates of service) WWI-Army		16b. SOCIAL SECURITY NO. 577-03-6627	17 INFORMANT Patinet's chart
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral thrombosis & Uremia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe Atherosclerosis. Cerebral Thrombosis</u> Months					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>XX Congestive Heart Failure</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this-hospital) attended the deceased from <u>MAY</u> , 19 <u>63</u> , to <u>Nov 27</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov. 27</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Robert B. Frey</u>			22c. DATE SIGNED 11-28-68		
22d. PHYSICIAN'S NAME (Type) ROBERT B. FREY			22e. ADDRESS 11161 New Hampshire Ave Silver Spring		
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE Dec. 2, 1968	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Md	
24. FUNERAL DIRECTOR <u>Walter</u>	25a. REC'D BY REGISTRAR DATE DEC 2 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
§ 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16087

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1610

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last MARY K FRANCIS			2a. DATE OF DEATH Month Day Year 11 11 68			2b. HOUR 6:10 AM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH 5-1-04		6. AGE (In years lost birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) H. WIFE			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY m.		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7402 HADCOCK AVE NDE			
14. FATHER'S NAME First Middle Last JOSEPH MORRIS			15. MOTHER'S MAIDEN NAME First Middle Last SARAH MANOANYOHL								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO.		17. INFORMANT EDWIN ALLEN FRANCIS, 1512 Belger Rd. Laurel						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emboli ADENOCARCINOMA 11-11-11 DUE TO, OR AS A CONSEQUENCE OF WITH WIDE SPREAD METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) 10mos APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1992											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from January, 1968, to Nov 11, 1968, that (I) (we) last saw the deceased alive on Nov 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Blaine H. Eig		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Nov 11, 1968					
22d. PHYSICIAN'S NAME (Type) BLAINE H. EIG		22e. ADDRESS 7801 Deoria Ave Beltsville, Md.									
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE Nov 13, 1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Md					
24. FUNERAL DIRECTOR J. Arthur Walters		25a. REC'D BY REGISTRAR DATE NOV 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16088

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1610

1. DECEASED NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR	
HERMAN		M.			NOVEMBER 23 1968			3 ¹⁵ -M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.
MALE	CAUCASIAN		12-20-00		67 YRS.		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
PENNSYLVANIA		U.S.A.				MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		HOLY CROSS HOSPITAL		RODUCER/MENTHANT (R)		FOOD			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.		MONT.		SILVER SPRING		YES		1209 EDGEVALE ROAD	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
UNKNOWN		RACHEL		UNKNOWN		A. FRED FREEDMAN		SAME AS 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4/154 DUE TO, OR AS A CONSEQUENCE OF (b) 4/154 DUE TO, OR AS A CONSEQUENCE OF (c) 4/154		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
CONGESTIVE HEART FAILURE		BILAT. BRONCHOPNEUMONIA							
ARTERIO SCLEROTIC HEART DISEASE									
ENDOCARDIAL MURAL THROMBOSIS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
4200									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from APRIL 1965 to NOV. 23 1968, that (I) (we) lost saw the deceased alive on NOV. 23 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Albert H. Grollman		22c. DATE SIGNED 11/24/68					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ADDRESS					
ALBERT H. GROLLMAN		1106 SPRING ST SILVER SPRING							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		11-25-1968		ROOSEVELT CEMETERY		BUCKS COUNTY PA.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Crescent Funeral Home 4217 9th St NW		DATE NOV 26 1968		J. Charles Judge					



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

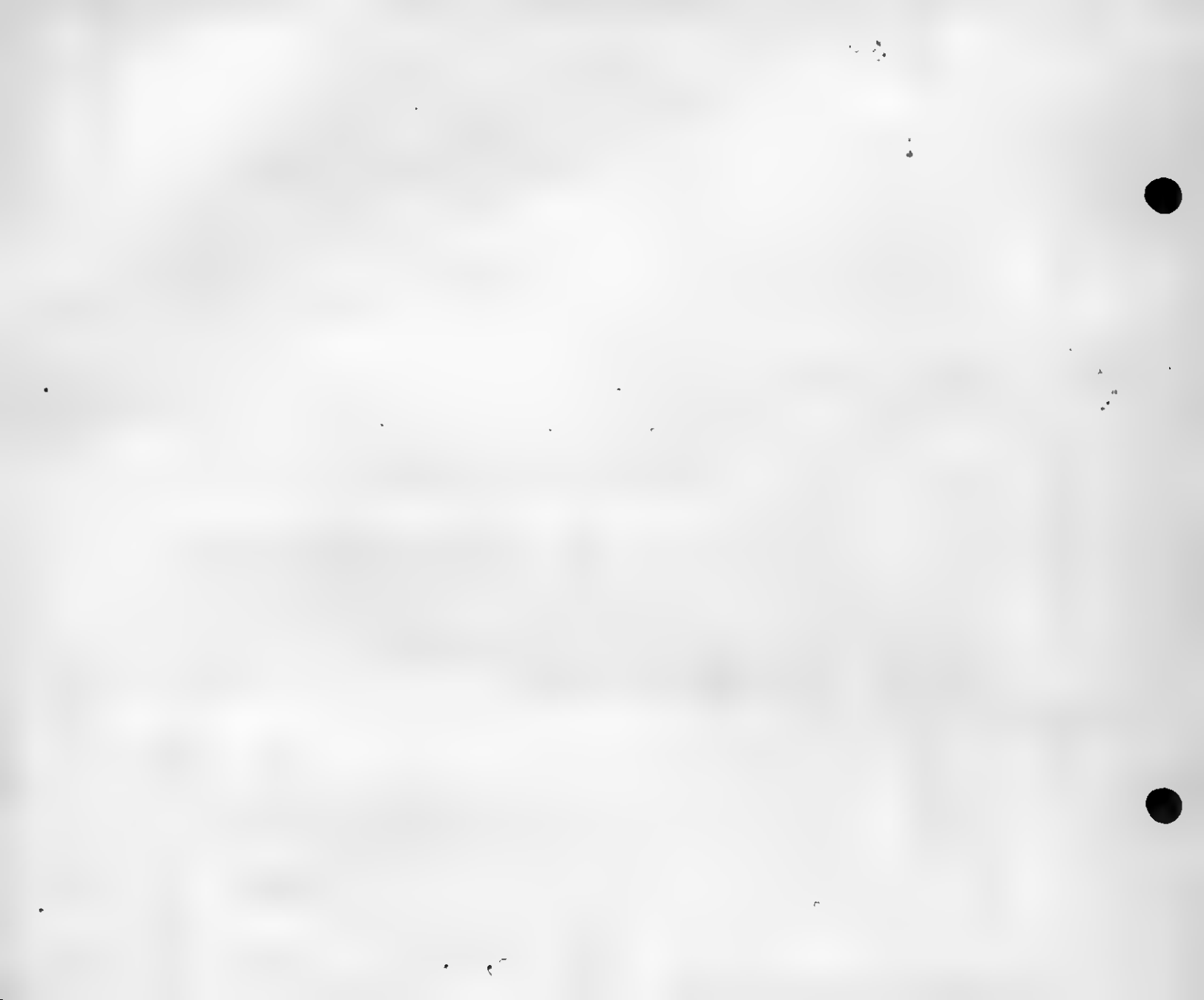
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16103

16089

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) JOHN CURTIS FRIZZELL			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 11 14 1968			2b HOUR - 2 A.M.			
3 SEX Male	4 RACE White	5. DATE OF BIRTH 3-15-1917	6. AGE (In years last birthday) 51 YRS	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0 MIN.	2c DATE PRONOUNCED DEAD Month Nov Day 14 Year 1968			
7a. BIRTHPLACE (State or foreign country) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3 Kemp Court -			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Assembler		12b KIND OF BUSINESS OR INDUSTRY Electronics		
13a USLA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE md.			13b COUNTY Montgomery			13c CITY OR TOWN Rockville			
14. FATHER'S NAME First John C. Middle Freizzell Last Dean			15. MOTHER'S NAME First Dean Middle Mason Last Mason			13d STREET AND NUMBER #3 Kemp Court			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) W.W. 2			16b SOCIAL SECURITY NO 217-32-1598		17 INFORMANT ADDRESS Virginia H. Frizzell Rockville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Marked coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 1109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 400									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John E. Ball			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b DATE SIGNED Nov 14 / 1968			
23a BURIAL, CREMATION, REMOVA (Specify) Burial		23b DATE 11/17/68		23c NAME OF CEMETERY OR CREMATORY Union		23d LOCATION (City or Town) (County) (State) Leesburg Loudoun Va.			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home				1351 Rockville Pike Rockville, Md.		25. REC'D BY REGISTRAR DATE NOV 18 1968		25b REGISTRAR'S SIGNATURE Charles Judge	

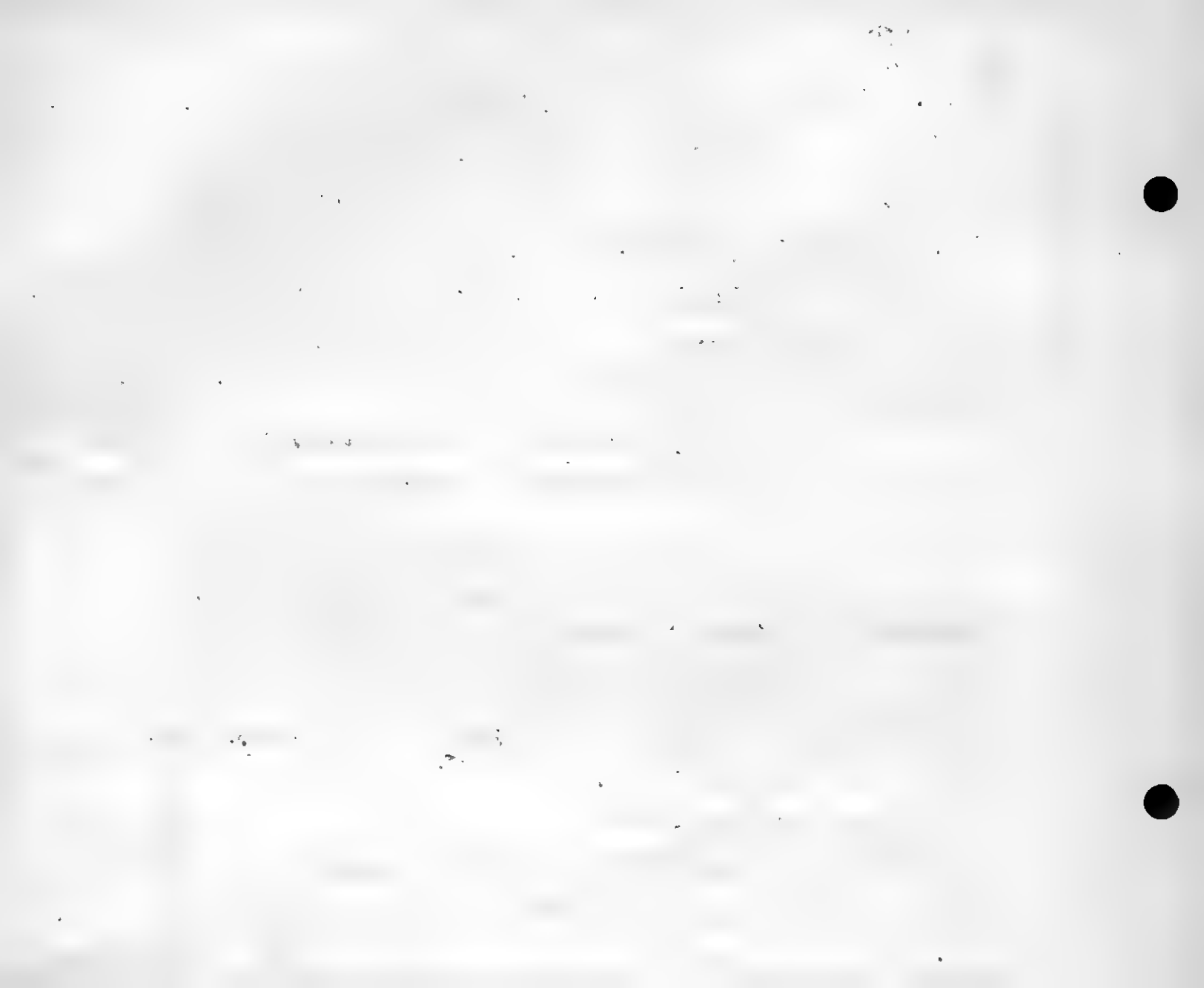


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) CHARLIE R. GARDNER						2a. DATE OF DEATH Month 11 Day 3 Year 1968			2b. HOUR 1250 M.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 6/22/97			6. AGE (In years last birthday) 71 YRS.		F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH SILVER SPRINGS			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institut an. Residence before admission) STATE MD.			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN MT RAINIER		13d. INSIDE CITY LIM TSP YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3121 QUEENS CHAPEL Rd.	
14. FATHER'S NAME First Thomas Middle Gardner				15. MOTHER'S M.A.DEN NAME First Elizabeth Middle Hanks							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown no (if yes give war or dates of service)				16b. SOCIAL SECURITY NO. 230 09 9272		17. INFORMANT Maude B. Gardner			Address Mt Rainier, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 1621 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma L. lung DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo. 18 mo.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 163X											
19a. DATE OF OPERATION Aug 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma L. lung				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (1) (this hospital) attended the deceased from Aug , 1967, to Nov 3 , 1968, that (1) (we) last saw the deceased alive on Nov. 3 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James R. Coleman MD						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Nov. 3, 1968			
22d. PHYSICIAN'S NAME (Type) JAMES R. COLEMAN MD						22e. ADDRESS 9241 COLUMBIA BLVD SILVER SPRING, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov 7, 1968		23c. NAME OF CEMETERY OR CREMATORY Gardner family cemetery			23d. LOCATION (City or Town) (County) (State) Hillsville Carroll Va.				
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR DATE NOV 7 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16093										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16105	
CERTIFICATE OF DEATH																					
1. DECEASED NAME (Type or print) -				First Middle Last				2a. DATE OF DEATH				2b. HOUR									
FREDERIC				GISLER				11 Month 14 Day 68 Year				8:30 AM									
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.									
M		W		7-14-1890				178 YRS.		MONTHS DAYS		HOURS MIN.									
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH				Md									
Switzerland		United States		WIDOWED		DIVORCED		MONTGOMERY													
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY									
TAKOMA PARK				#1 Barclay Avenue				Retired				Chef									
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) - STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER											
Maryland				Montgomery		Takoma Park		YES NO		#1 Barclay Avenue											
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																	
First Middle Last				First Middle Last																	
-				Henrieta				Rossell													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT				Address											
no				-		Mrs. Agnes Gisler, Wife, same as item #13															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY.																					
IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i>												3 HRS.									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Sclerosis</i>												3 years.									
DUE TO, OR AS A CONSEQUENCE OF (c)																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)																					
<i>Acute Myocardial Infarction: July 1966 and July 1968.</i>																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
								YES NO													
21a. ACCIDENT WAS UNDERLYING				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				HOUR A.M. Month Day Year																	
				P.M. 19																	
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION				City or Town County State									
While <input type="checkbox"/> Not while <input type="checkbox"/>								Street or R.F.D. No													
at work <input type="checkbox"/> at home <input type="checkbox"/>																					
22a. I certify that (I) (this hospital) attended the deceased from <i>July 1966</i> to <i>11/14 1968</i> , that (I) (we) last saw the deceased alive on <i>11/13/68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE				DEGREE				ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.									
<i>Samuel Desoff M.D.</i>								<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>									
22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS													
<i>11/14/68</i>				<i>SAMUEL DESOFF</i>				<i>1302-18 Smith Wash D.C.</i>													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)															
Cremation		11-16-1968		Cedar Hill Cemetery		Suitland, P.G. Co., Maryland															
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE													
<i>Joseph Gwiler's Sons, Inc., 9530 Ave. N.W., Wash., D.C., 20016</i>				DATE <i>NOV 18 1968</i>				<i>Charles J. J...</i>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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16092

CERTIFICATE OF DEATH

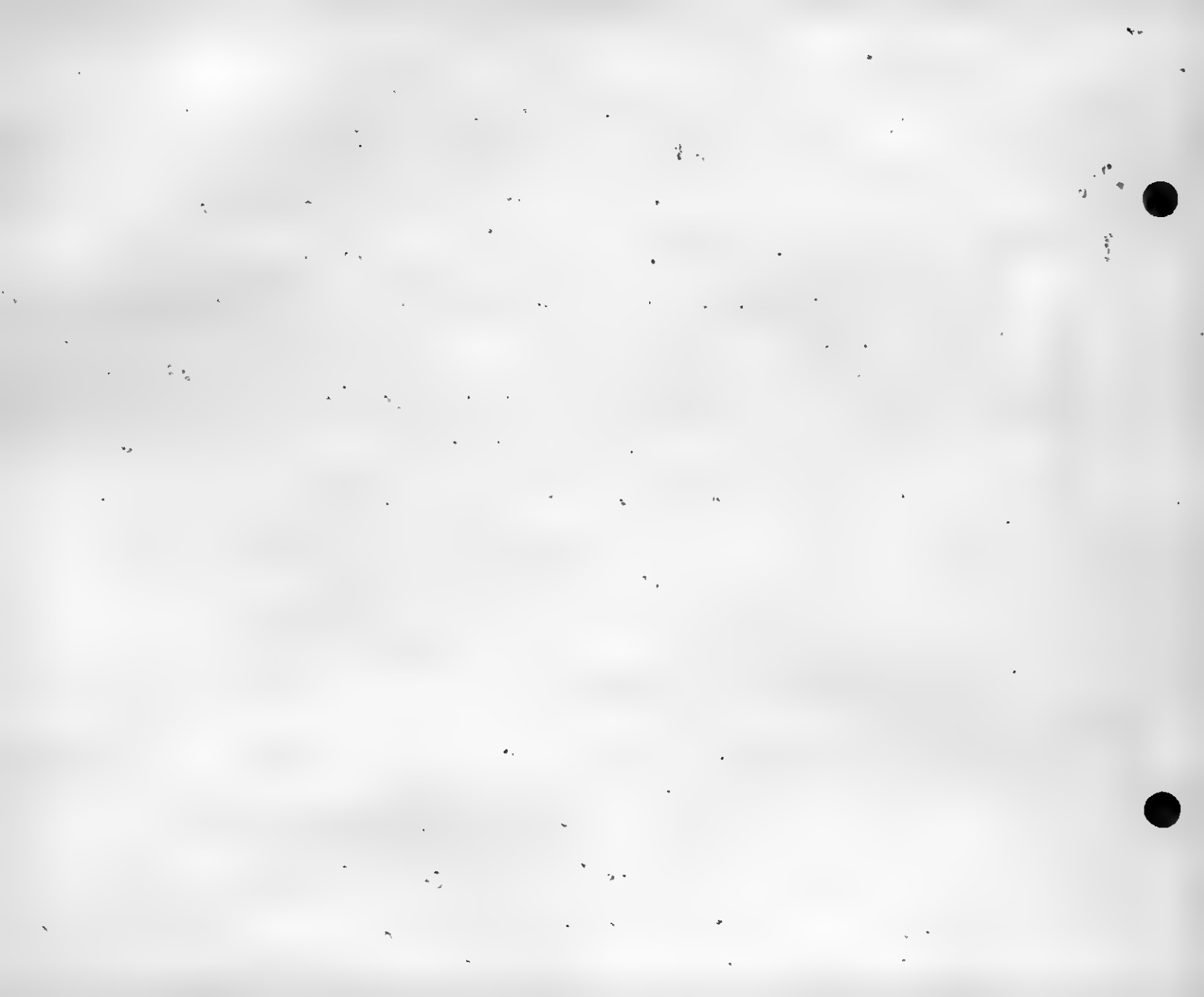
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
CARRIE LELIA GLOTFELTY						11-5-68			4:02pm		
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		White		10-28-70		98 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Oakland, Md.		U.S.A.				Montgomery Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park		Wash. San. & Hosp.				Housewife		own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Mont.		S.S.				307 Hillmoor Dr.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Stephen			Browning			Margaret Casteel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT						
No			217-36-8092		Mr. Joseph Glotfelty, S.S. Md. 307 Hillmoor Dr. (Son)						
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE CARDIAC FAILURE</u>										4 HOURS	
7124 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>										10 YEARS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
1-21											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 1967</u> , to <u>NOVEMBER 1968</u> , that (I) (we) lost saw the deceased alive on <u>OCT 10 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS		MED D RECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
<u>Robert L. Krichmar</u>								5 NOVEMBER 1968			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
ROBERT L. KRICHMAR M.D.		7733 ALASKA AVENUE N.W. WASHINGTON D.C. 20012									
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		11-8-1968		Oakland Cemetery		Oakland, Maryland					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Warner E. Humphrey, Inc.		8434 Ga. Avenue S. S., Md.		NOV 12 1968		Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers- Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Reap, coroner, approved

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16092 CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First <u>BESSIE</u> Middle <u>GOLDNER</u> Last <u>GOLDNER</u>				2a. DATE OF DEATH Month <u>Nov</u> Day <u>19</u> Year <u>1968</u>				2b. HOUR <u>7:30 P</u>			
3. SEX <u>FEMALE</u>				4. RACE <u>CAUCASIAN</u>				5. DATE OF BIRTH <u>3-5-1897</u>			
6. AGE (In years last birthday) <u>71</u> YRS				IF UNDER 1 YEAR MONTHS <u>71</u> DAYS <u>71</u>				IF UNDER 24 HRS HOURS <u>71</u> MIN <u>71</u>			
7a. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>				7b. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. COUNTY OF DEATH <u>MONTGOMERY</u>				10. CITY OR TOWN OF DEATH <u>SILVER SPRING</u>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1401 BLAIR MILL ROAD AT HOME</u>			
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>AT HOME</u>				12b. KIND OF BUSINESS OR INDUSTRY				13a. US JAIL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>			
13b. CITY OR TOWN <u>SILVER SPRING</u>				13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13d. STREET AND NUMBER <u>1401 BLAIR MILL ROAD #804</u>			
14. FATHER'S NAME First <u>SHOYA</u> Middle <u>JAMPOLSKY</u> Last <u>GILBERT</u>				15. MOTHER'S MAIDEN NAME First <u>YENTA</u> Middle <u>GILBERT</u> Last <u>GILBERT</u>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <u>2-22-14-9261</u>				17. INFORMANT <u>MR. SEYMOUR GOLODNER, SON, 12911 BENTLEY</u>				Address <u>LA., BOWIE, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS, ACUTE</u>										<u>Several hours</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic & hypertensive Cardio-Vasc. disease</u>										<u>10 yrs.</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>4201</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes mellitus</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. <u>19</u> Month <u>19</u> Day <u>19</u> Year <u>19</u>			
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			
21f. LOCATION Street or R.F.D. No. City or Town County State				22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 5</u> , 19 <u>68</u> , to <u>Nov 19</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct. 31</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE <u>Irwin I. Yager M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. DATE SIGNED <u>Nov. 20, 1968</u>				22d. PHYSICIAN'S NAME (Type) <u>IRWIN I. YAGER M.D.</u>				22e. ADDRESS <u>3055-16th St. N.W., WASH. DC. 20009</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE <u>11-21-1968</u>				23c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID CEMETERY</u>			
23d. LOCATION (City or Town) (County) (State) <u>FAIRFAX CO., VIRGINIA</u>				24. FUNERAL DIRECTOR <u>JOSEPH CAWLER, INC., 5130 WISC. AVE. N.W., WASH., D.C., 20016</u>				25a. REC'D BY REGISTRAR <u>NOV 25 1968</u> DATE			
25b. REGISTRAR'S SIGNATURE <u>Judge</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 4 Film 6406 11/12/68
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16108

1. DECEASED-NAME (Type or print) First Middle Last Jennie Zelda Gordon			2a. DATE OF DEATH Month Day Year Nov 3 1968			2b. HOUR 2 P M	
3 SEX F		4. RACE Jewish White		5. DATE OF BIRTH 10 - - 01		6. AGE (In years last birthday) 67 YRS.	
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Silver Spring Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Colonial Villa		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Gov't clerk		12b. KIND OF BUSINESS OR INDUSTRY PATENT OFFICE	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 13128 Valleywood Drive		14. FATHER'S NAME First Middle Last Louis Berg		15. MOTHER'S MAIDEN NAME First Middle Last Sarah			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 578-40-7789		17. INFORMANT son-in-law Charles Grossman		Address S.S. Md. 13128 Valleywood Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis 114X DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Carcinoma breast, left, primary APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos. 8 yrs.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 110A							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Oct 1, 1968 19__, to Nov. 2, 1968 , that (I) (we) last saw the deceased alive on 11/2/68 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A.W. Smith M.D.				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 11/2/68	
22d. PHYSICIAN'S NAME (Type) A.W. SMITH				22e. ADDRESS 13018 GEORGIA AVE WHEATON, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11-4-68		23c. NAME OF CEMETERY OR CREMATORY GEORGE WASH. CEM.		23d. LOCATION (City or Town) (County) (State) HYATTSVILLE, 1 MD.	
24. FUNERAL DIRECTOR Goldberg Funeral Home				ADDRESS 4717 N. Oltman		25a. REC'D BY REGISTRAR DATE NOV 6 1968	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16095

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16109

1. DECEASED NAME (Type or Print) <u>James R. Grapp</u>			2a. DATE KNOWN OF DEATH EST. <input type="checkbox"/> Month Day Year MATED <input type="checkbox"/> <u>16 Nov.</u> <u>1968</u> <u>5:30</u> PM		
3. SEX <u>M.</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>July 20-1917</u>	6. AGE (in years last birth) <u>51</u> YRS	7. UNDER 24 HRS MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year <u>Nov.</u> <u>16</u> <u>1968</u> <u>5:30</u> PM
7a. BIRTHPLACE (State or foreign country) <u>Penna</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <u>Montgomery</u>		10. CITY OR TOWN OF DEATH <u>Bethesda</u>			
11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Suburban</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Spec. with AS Remedy World Report</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Bethesda</u>	
14. FATHER'S NAME <u>Otto Grapp</u>		15. MOTHER'S MAIDEN NAME <u>Bertie B. Schweinler</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>WW II</u> <u>A.F.</u>	
16b. SOCIAL SECURITY NO. <u>196-03-9541</u>		17. INFORMANT <u>Esther Grapp</u>		ADDRESS <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency acute</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Arteriosclerosis Severe</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>+</u> <u>101</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John B. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>11/17/68</u>	
EXAMINER'S NAME (Type) <u>John B. Ball</u>		ADDRESS (Street, city, town, or county) <u>Columbia, South Carolina</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Removal-Burial</u>		23b. DATE <u>11-19-1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Crescent Hill Gardens</u>	
23d. LOCATION (City or Town) (County) (State) <u>Columbia, South Carolina</u>		24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc., 5130 Wiso Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 22 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>John B. Ball</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16096

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

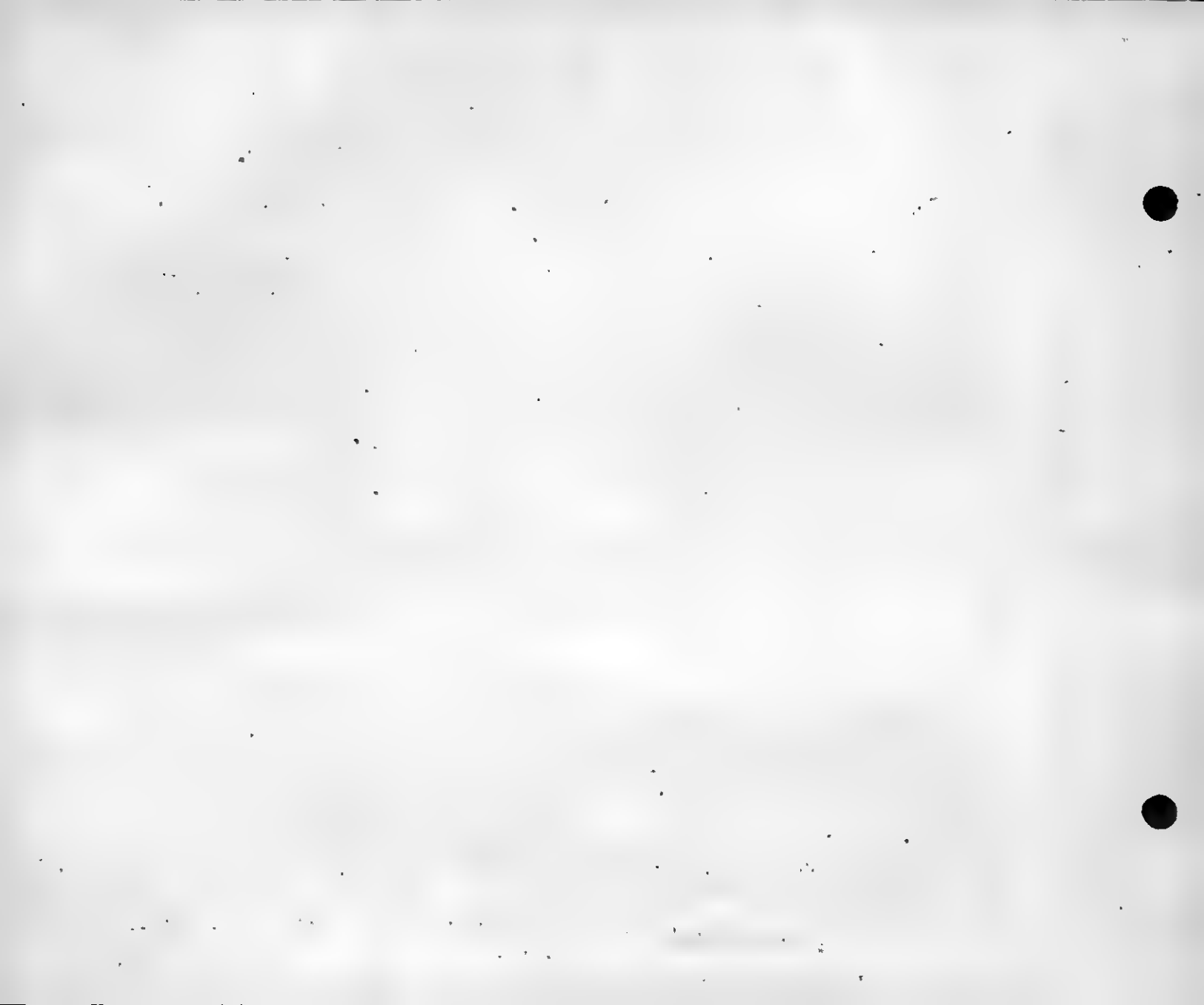
16111

1 DECEASED-NAME (Type or print) Hugh J. GRANGER			2a. DATE OF DEATH Month 11 - Day 10 - Year 68			2b. HOUR- 10:30 P.M.	
3 SEX MALE		4 RACE White		5. DATE OF BIRTH 9-14-88		6 AGE (In years last birthday) 80 YRS.	
7a. BIRTHPLACE (State or foreign country) Scotland		7b. CIT ZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington D.C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 66 H 3rd Place NW							
14. FATHER'S NAME First James Middle Shogren Last Granger			15. MOTHER'S MAIDEN NAME First Annie Middle Sealin Last Granger				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO 579-26-6363		17. INFORMANT MARY GRANGER		Address 135	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4200							
(b) ARTERIOSCLEROTIC HEART DISEASE							
(c) CEREBRAL VASCULAR INSUFFICIENCY							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (th's hospital) attended the deceased from OCT 31, 1968 , to Nov. 10, 1968 , that (I) (we) last saw the deceased alive on Nov. 10, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Joseph D. Connor MD		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11 NOV. 68	
22d. PHYSICIAN'S NAME (Type) JOSEPH D. CONNOR MD		22e. ADDRESS 9420 OLD GEORGETOWN RD Bethesda					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11/13/68		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION (City or Town) (County) (State) SILVER SPRING MD	
24. FUNERAL DIRECTOR HANCOX FUNERAL HOME - WASH D.C.		ADDRESS		25a. REC'D BY REGISTRAR NOV 18 1968		25b. REGISTRAR'S SIGNATURE John Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

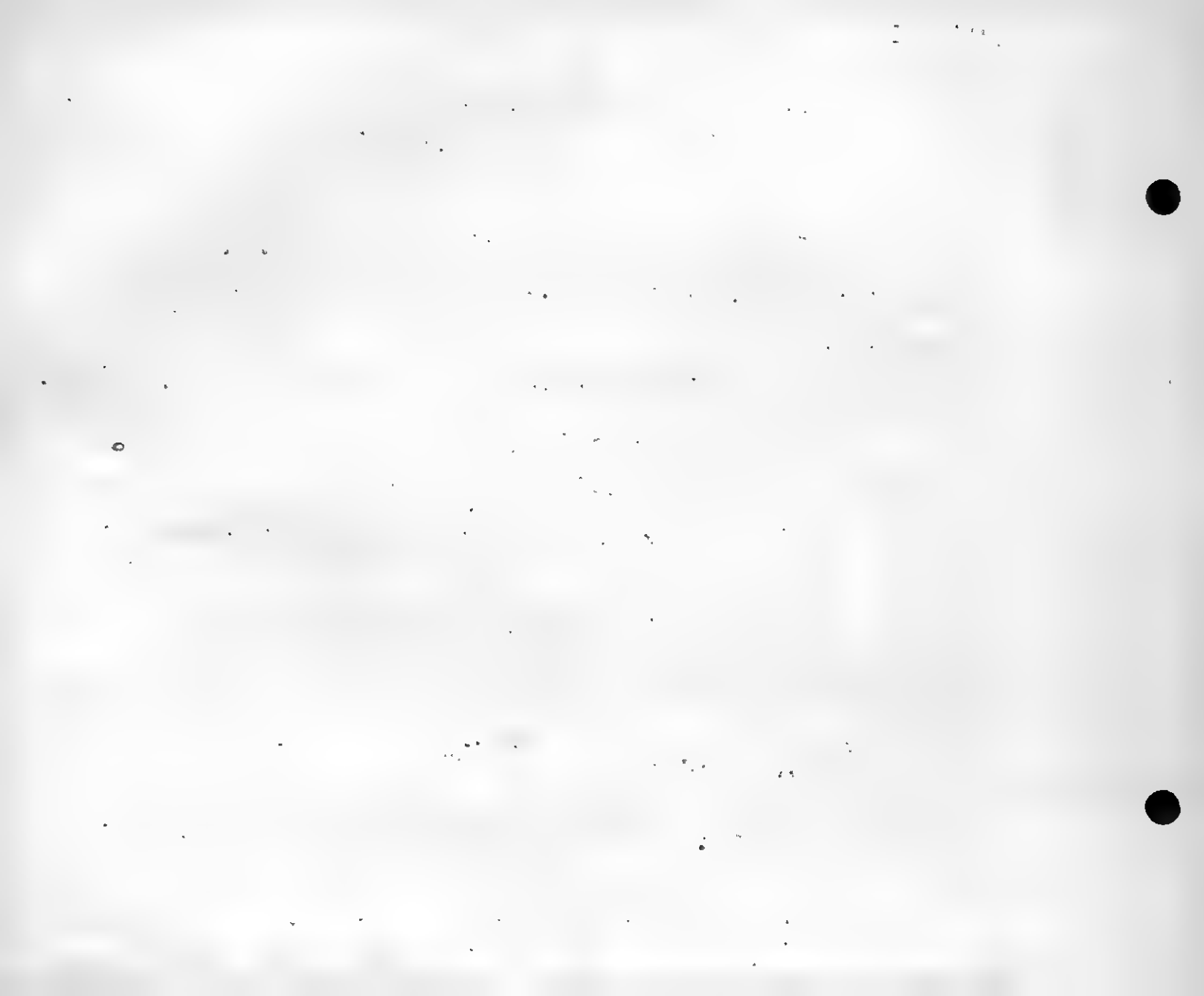
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) ^{First} <u>Cora</u> ^{Middle} <u>Geiger</u> ^{Last} <u>Green</u>					2a DATE OF DEATH ^{Month} <u>11</u> ^{Day} <u>25</u> ^{Year} <u>1968</u>		2b HOUR <u>6:55PM</u>		
3 SEX <u>Female</u>		4 RACE <u>White</u>		5. DATE OF BIRTH <u>5-21-1980</u>		6 AGE (In years lost birthday) <u>88</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <u>Ohio</u>		7b CITIZEN OF WHAT COUNTRY? <u>United States</u>		8- MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery Co.</u> Md.			
10 CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>At the old land Mrs. Home</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Housewife</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Own home</u>			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Maryland</u>		13b COUNTY <u>Montgomery</u>		13c CITY OR TOWN <u>Bethesda</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <u>5501 Kirkwood Dr.</u>	
14. FATHER'S NAME ^{First} <u>Albert</u> ^{Middle} <u>—</u> ^{Last} <u>Geiger</u>			15. MOTHER'S MAIDEN NAME ^{First} <u>Caroline</u> ^{Middle} <u>—</u> ^{Last} <u>Russer</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>No</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. W. E. Ackerman</u>		Address <u>5501 Kirkwood Dr. Wash. D.C. 20016</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>411</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u> Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>65</u> , to <u>Nov</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov 25</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Bernard A. Fitzgerald</u> DEGREE <u>MD</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>11-25-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>				22e. ADDRESS <u>217 UNIV. BLVD. E., SILVER SPRING, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>11-26-1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Reister Pr. Geos., Maryland</u>			
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>				ADDRESS <u>Sil. Spr. Md.</u>		25a. RECD BY REGISTRAR <u>NOV 29 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Abraham		Middle Green		Last blat		2a. DATE OF DEATH Month 11 Day 3 Year 68		
3. SEX M		4. RACE White		5. DATE OF BIRTH 9-15-96		6. AGE (in years last birthday) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Silver Spring, MD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED MERCHANT			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8708 FIRST AVE.	
14. FATHER'S NAME UNKNOWN				15. MOTHER'S MAIDEN NAME UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO 579-46-4376-A			17. INFORMANT BALFOUR S. GREEN BLAT			Address 12624 EASTBOURNE Silver Spring, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 153.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Peritonitis & uremia DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of the Colon with obstruction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 weeks 2 mos?											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 153.2											
19a. DATE OF OPERATION 10-7-68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 1) Ca of Colon 2) Peritonitis & Abscess			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10-4-68, 19, to 11-3-1968, that (II) (we) last saw the deceased alive on 11-3-68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (II) (we) did (did not) view the body after death.											
22b. SIGNATURE Marie Perry M.D.			DEGREE ATTENDING PHYS.			<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 11-3-68		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE Nov. 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Ohev Shalom Talmud Torah Cemetery			23d. LOCATION (City or Town) (County) (State) Washington, D.C.			
24. FUNERAL DIRECTOR Donald M. Stein			ADDRESS 232 Carroll St., N.W. Wash., D.C.			25a. REC'D BY REGISTRAR NOV 7 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and in any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> 16093 INTERSTATE 6, Film 407 12/3/68 km CERTIFICATE OF DEATH </div>									
1 DECEASED NAME (Type or print)			First MARY Middle M. Last GREENFIELD			2a DATE OF DEATH NOV Month 15 Day 68 Year		2b HOUR 4:50 P.M.	
3 SEX FEMALE		4 RACE NEGRO		5 DATE OF BIRTH 11/27/1927		6 AGE (In years last birthday) 40 YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY COUNTY Md			
10 CITY OR TOWN OF DEATH SILVER SPRING.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) FAIRLAND NURSING HOME		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE DIST. COL.		13b COUNTY WASHINGTON D.C.		13c CITY OR TOWN WASHINGTON D.C.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1745 S B N.W.	
14 FATHER'S NAME First JAMES Middle R. Last GREENFIELD			15 MOTHER'S MAIDEN NAME First ELIZABETH Middle M. Last GROSS						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO. 578-68-8876		17. INFORMANT HOSPITAL RECORD -		Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR COLLAPSE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ANEMIA, CHRONIC RENAL DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF <u>DIGESTIVE DYSFUNCTION</u> (c) <u>ASCID. CHF</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from 11/10/68, to 11/18/68, that (I) (we) last saw the deceased alive on 11/13/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Allen B. Cohen, M.D.					22c DEGREE M.D. ATTENDING PHYS		22d MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22e DATE SIGNED 11/14/68
22d. PHYSICIAN'S NAME (Type) Allen B. Cohen, M.D.					22e. ADDRESS 13575 Georgia Ave S.S. Md.				
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b DATE 11/20/68		23c NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d LOCATION (City or Town) (County) (State) WASHINGTON, D.C.			
24 FUNERAL DIRECTOR Robert J. McShine 1820-9th St. N.W.					25a REC'D BY REGISTRAR NOV 21 1968		25b REGISTRAR'S SIGNATURE [Signature]		



1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) Lucy Tapp Gregg				First Middle Last				2a DATE OF DEATH Month Day Year Nov. 11, 1968			2b HOUR 10:25 PM
3 SEX F		4 RACE W		5. DATE OF BIRTH July 13, 1890			6. AGE (in years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md					
10. CITY OR TOWN OF DEATH Woodfield			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rt. #1 Gaithersburg			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) H. wife			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Rt. #1		
14. FATHER'S NAME First Middle Last James Richard Tapp				15. MOTHER'S MAIDEN NAME First Middle Last Lucy - Edwards							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give year or dates of service)			16b. SOCIAL SECURITY NO 217-48-8382		17 INFORMANT Address James N. Gregg Mt. Airy, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cystadenocarcinoma of the ovary with grossly metastatic 1830 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1950											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 4/9 , 19 65 , to 11/11 , 19 68 , that (I) (we) last saw the deceased alive on 11/11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James P. Kerr				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/12/68			
22d. PHYSICIAN'S NAME (Type) James P. Kerr				22e. ADDRESS Damascus, Md.							
23a. BURIAL, CREMATION REMOVAL Burial		23b. DATE 11-14-68		23c. NAME OF CEMETERY OR CREMATORY Laytonsville				23d. LOCATION (City or Town) (County) (State) Laytonsville Mont. Md.			
24. FUNERAL DIRECTOR Francis H. Barber				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 14 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 16 and Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
10M REV 1/66

16101

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16115

1 DECEASED NAME (Type or Print) Ernest Eugene Hackey			2a DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Nov-19 19 68			2b HOUR 2 4 M		
3. SEX M.	4 RACE Negro	5 DATE OF BIRTH 12-13-1935	6 AGE (In years last birthday) 32 YRS	IF UNDER 1 YEAR MONTHS DAYS 	IF UNDER 24 HRS HOURS MIN 	2c DATE PRONOUNCED DEAD Month Nov Day 19 Year 1968		2d HOUR 8 A M
7a. BIRTHPLACE (State or foreign country) md		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 101 Dawson Ave.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD			13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Harvey Middle Lee Last Hackey Sr			15. MOTHER'S MAIDEN NAME First Odie Middle Odessa Last Snowden					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b SOCIAL SECURITY NO. 220-34-9001		17 INFORMANT ADDRESS HARVLY HACKEY, CLARKSBURG, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis Acute DUE TO, OR AS A CONSEQUENCE OF (b) Perforation of Gastric Ulcer - DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5401								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John G. Ball			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED Nov. 19, 1968		
EXAMINER'S NAME (Type) John G. Ball			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county) Bethesda, Md								
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 11-23-1968		23c NAME OF CEMETERY OR CREMATORY Fairview		23d LOCATION (City or Town) Frederick (County) Fred. (State) MD		
24 FUNERAL DIRECTOR C.E. Hicks, 111 Frederick, Md				ADDRESS		25a. REC'D BY REG STRAR NOV 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16102

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16116

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <u>PEARL</u> <u>Lawson</u> <u>HAFFNER</u>			2a. DATE OF DEATH Month <u>11</u> Day <u>20</u> Year <u>68</u>			2b. HOUR <u>6:50</u> A.M.	
3. SEX <u>FEMALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH <u>2-22-90</u>		6. AGE (In years last birthday) <u>78</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>MD.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery County</u> Md.	
10. CITY OR TOWN OF DEATH <u>Silver Spring Md.</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Spring</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <u>William</u> Middle <u>Lance</u> Last <u>Wilson</u>		15. MOTHER'S MAIDEN NAME First <u>Frances</u> Middle <u>Wilson</u> Last <u>Wilson</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16b. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Erich W. Haffner</u>		Address <u>Sil. Spr., Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> <u>4401</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hemorrhagic necrosis of small & large</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>45</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>1959</u> , to <u>November 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov 20</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Raymond Bradshaw</u>				22c. DATE SIGNED <u>11/20/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw, M.D.</u>				22e. ADDRESS <u>345 University Blvd. West</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-22-1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville Montgomery Md.</u>	
24. FUNERAL DIRECTOR <u>J.W. Lee</u> <u>Warner E. Pumphrey, Inc. 8434 Ga. Avenue</u>				25a. REC'D BY REGISTRAR <u>NOV 27 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



CERTIFICATE OF DEATH

16103

16111

1. DECEASED NAME (Type or print) JACOB A. HAKE			2a. DATE OF DEATH Month NOVEMBER Day 10 Year 1968			2b. HOUR M	
3 SEX Male		4. RACE White		5. DATE OF BIRTH 10-4-1880		6. AGE (in years last birthday) 88 YRS	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County Md.	
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) POTOMAC VALLEY NURSING		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Cons. Engineer		12b. KIND OF BUSINESS OR INDUSTRY Constructive	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) Washington, D. C.		13b. CITY OR TOWN Washington		13c. HAS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 812 Madison St., N. W.	
14. FATHER'S NAME First Daniel Middle W. Last Hake			15. MOTHER'S MAIDEN NAME First Anna Middle Jane Last Wagner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. unknown		17 INFORMANT Address Olive M. Hake 812 Madison St., N. W.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) stroke DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 10 yr Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 wk
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 334X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from June 15, 1967 to Nov 10, 1968 , that (I) (we) last saw the deceased alive on Oct 24, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Arthur H. Lewis M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) ARTHUR H. LEWIS				22e. ADDRESS 1733 N St NW Wash DC			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 11-14-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Pr. Geo. Md.	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland				25a. REC'D BY REGISTRAR NOV 18 1968		25b. REGISTRAR'S SIGNATURE Thomas Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
<div style="display: flex; justify-content: space-between;"> 16104 CERTIFICATE OF DEATH 16118 </div>													
1 DECEASED NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH Month Day Year		2b HOUR P		
			Michael		James		Hall		November 3 1968		4:00 PM		
3. SEX			4 RACE			5 DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male			White			3 June 1967			1 YRS		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Hong Kong			USA						Montgomery Md				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY				
Bethesda			The Clinical Center, NIH			Child							
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY - MITS?		13e STREET AND NUMBER		
Virginia			Fairfax			McLean			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1914 Hyannis Court, apt. 202		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last	
			William		James		Hall		Carol			Ann Fefolt	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT							
No			None			The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram negative sepsis</u> <u>2 + 0</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Lymphocytic Leukemia</u>										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH			
										3 days			
										4 days			
										1 year			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION													
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED													
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)													
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19													
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>													
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC													
21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (X) (this hospital) attended the deceased from <u>12 June</u> , 19 <u>68</u> , to <u>3 Nov.</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>3 November</u> , 19 <u>68</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Harmon J. Eyre</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>													
22c. DATE SIGNED <u>4 November 1968</u>													
22d. PHYSICIAN'S NAME (Type) <u>Harmon J. Eyre, M.D.</u>													
22e. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Maryland</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify)													
23b. DATE <u>11-6-68</u>													
23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>													
23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Fairfax, Va.</u>													
24. FUNERAL DIRECTOR <u>Money & King Funeral Home, Vienna, Va.</u> ADDRESS													
25a. REC'D BY REGISTRAR DATE <u>NOV 12 1968</u>													
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>													



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR
Donna Ann Hanna						Month 11 Day 25 Year 1968			9:57 M
3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD	
Female	Caucasian	9-14-52	16 YRS.					Month 11 Day 25 Year 1968 9:57 M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
District Columbia		USA				Montgomery Md			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring			Holy Cross			STUDENT			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.			Montgomery			Wheaton		3613 Ralph Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Ray B. Hanna			Vivian A. JOHNSTON						
16a. WAS DECEASED IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT			
No			NONE			Father Ray B. Hanna ADDRESS Same as Item 13.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 314.7 Multiple Extreme Injuries DUE TO, OR AS A CONSEQUENCE OF (b) with Intracranial Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 and Part 2, Item 18)			
			8:30 PM 11-22-1968			Deceased ran into pathway of oncoming auto and was run down			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			2 f. LOCATION Street or Rte No City or Town County State			
			Street			Silver Spring Montgomery Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER						
Belden R. Keap			DEPUTY MEDICAL EXAMINER						
			ADDRESS (Street, City, Town, or County)			Nov. 25, 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Burial			11-27-68			Parklawn Cemetery			Rockville, Maryland
24 FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE
ROBERT A. PUMPHREY, Bethesda, Maryland						DATE DEC 1 1968			Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

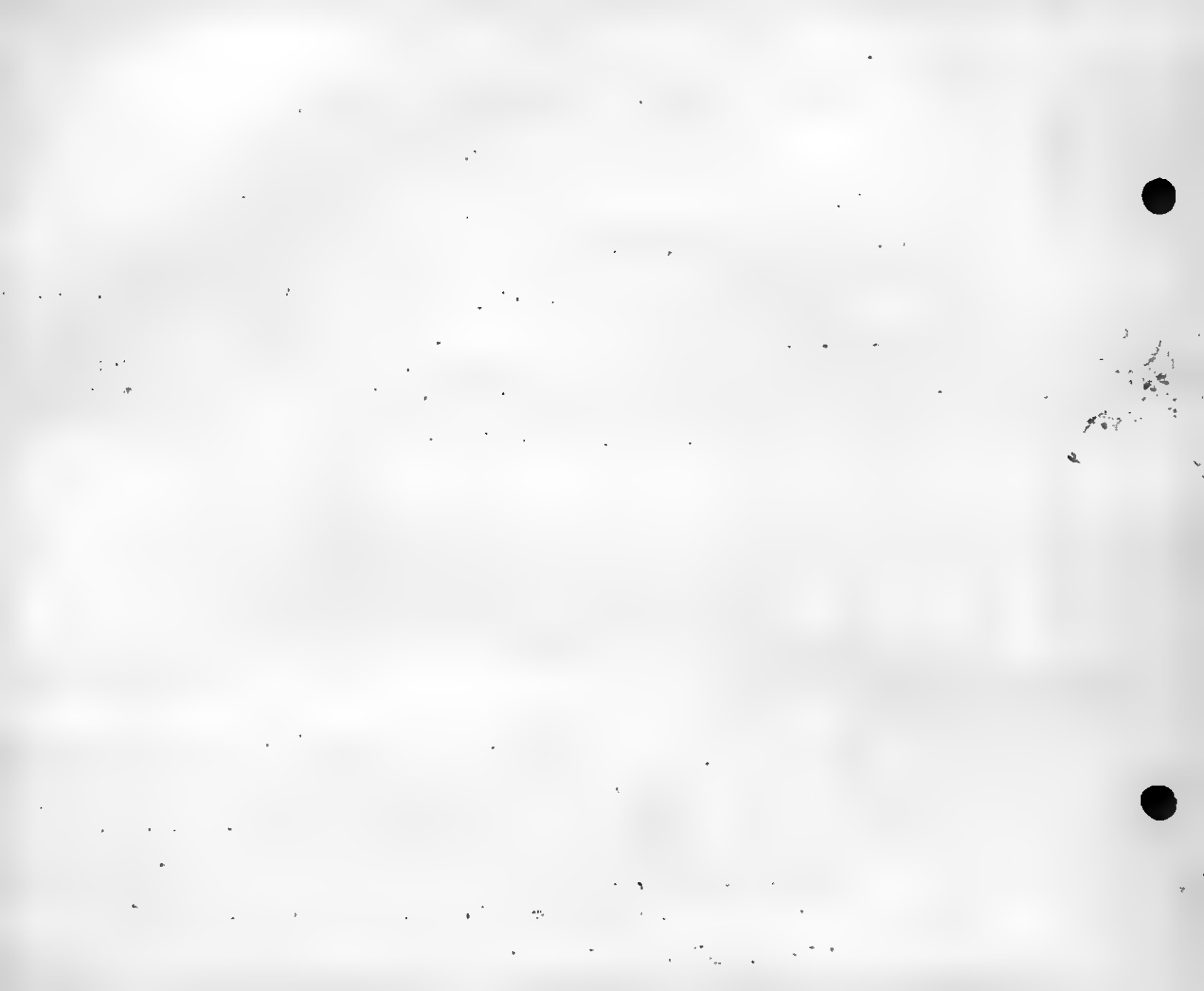
16106

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16120

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>Rosalie M Hansford</u>			2a. DATE OF DEATH Month <u>Nov</u> Day <u>24</u> Year <u>68</u>			2b. HOUR <u>5:10</u> AM	
3. SEX <u>Female</u>		4. RACE <u>white</u>		5. DATE OF BIRTH <u>6/1/23</u>		6. AGE (In years last birthday) <u>45</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery County Md.</u>	
10. CITY OR TOWN OF DEATH <u>Silver Spring, Md.</u>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Holy Cross Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Sil. Spr.</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <u>Clarence</u> Middle <u>Kawg</u> Last <u>Douglas</u>		15. MOTHER'S MAIDEN NAME First <u>Mary</u> Middle <u>Douglas</u> Last <u>Douglas</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>No</u> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <u>YES</u>		17. INFORMANT <u>Edwin Hansford</u> Address <u>Silver Spr., Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Ovary</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>11</u>							
19a. DATE OF OPERATION <u>11/24/68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 1, 1968</u> , to <u>Nov 24, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov 23, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Blaine H. Heig</u>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>11/24/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>BLAINE H. HEIG</u>		22e. ADDRESS <u>9101 Deoria Ave. Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-26-1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Parsons, West Virginia</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		C. Glen Carter ADDRESS <u>Sil. Spr. Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 29 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1612~

16103

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Victoria C. Hart</i>			2a. DATE OF DEATH Month <i>Nov</i> - Day <i>15</i> Year <i>1968</i>		2b. HOUR <i>9:30 A</i>
3. SEX <i>Female</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH <i>12/23/93</i>		6. AGE (In years last birthday) <i>74</i> YRS	7. UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>D.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery Co.</i> Md.		
10. CITY OR TOWN OF DEATH <i>Wheaton</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Kendall Hills Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>you t</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>257 Congressional Lane</i>	
14. FATHER'S NAME First <i>John</i> Middle <i>W.</i> Last <i>Hart</i>		15. MOTHER'S MAIDEN NAME First <i>Hannah</i> Middle <i>O'Connor</i> Last <i>O'Connor</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>579-60-1681</i>		17. INFORMANT <i>Catherine Chamberlain</i> Address <i>Rockville, Md. 257 Congressional Lane</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cerebral</i> DUE TO, OR AS A CONSEQUENCE OF <i>Complications of Trauma from</i> (b) <i>Motorcycle to Car</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Mitral Stenosis to Car</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 Weeks</i> <i>6 Months</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <i>1951</i>					
19a. DATE OF OPERATION <i>Sept 1948</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Tumor of colon</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l medical examiner)	21b. TIME OF INJURY HOUR A.M. <i>11</i> P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>8/10/68</i> , 19 <i>68</i> , to <i>11/15/68</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/14/68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.					
22b. SIGNATURE <i>E. Stuart Lyddane</i>		22c. DATE SIGNED <i>11/15/68</i>	22d. PHYSICIAN'S NAME (Type) <i>E. Stuart Lyddane</i>		
22e. ADDRESS <i>3066 2 Street, N. W., Washington, D. C.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>11-19-1968</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Prince Georges, Maryland</i>		
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		24a. ADDRESS <i>Silver Spr, Md.</i>	24b. REC'D BY REGISTRAR <i>NOV 25 1968</i>	24c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/78

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <u>BEATRICE S. HAUSER</u>			2a. DATE OF DEATH Month <u>11</u> Day <u>27</u> Year <u>68</u>			2b. HOUR <u>1:50</u> PM			
3. SEX <u>FEMALE</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>1-30-99</u>		6. AGE (In years lost birthday) <u>69</u> YRS.		IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>	
7a. BIRTHPLACE (State or foreign country) <u>Ind.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery County</u> Md.			
10. CITY OR TOWN OF DEATH <u>Silver Spring, Md.</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>HOUSEWIFE</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Spring</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>8104 PINEY BRANCH Rd.</u>	
14. FATHER'S NAME First <u>William</u> Middle <u>Schmidt</u> Last <u>Ann</u>			15. MOTHER'S MAIDEN NAME First <u>Ann</u> Middle <u>Overhausen</u> Last <u>Overhausen</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>579-09-6258</u>		17. INFORMANT <u>William L. Hauser</u>		Address <u>8104 PINEY BRANCH RD. SILVER SPRING, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gram negative Sepsis. Pseudomonas.</u> 2010 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Stem cell leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>> 2 months.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>weeks +</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>204.3</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>February</u> , 19 <u>47</u> , to <u>Nov. 27</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>Nov. 26</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. G. Graziani, M.D.</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>11/27/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>HUGO G. GRAZIANI, M.D.</u>		22e. ADDRESS <u>10101 GEORGIA AVE. S.S. MD.</u>							
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE <u>11/30/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 3 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



2
11
7



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15A (Rev. 11-68)
10A REV. 11-68

Items 18 & 22a Film 406 Maryland State Department of Health
11-21-68ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16124

16110

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Macie B. Hefner			2a. DATE KNOWN OF ESTIMATED DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year November 1 1968			2b. HOUR 3 A M		
3 SEX Female	4 RACE White	5 DATE OF BIRTH July 19, 1891	6 AGE (In years last birthday) 77 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> November 1, 1968		
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? Montgomery		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. & Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last James Whittier Whittier			15. MOTHER'S MAIDEN NAME First Middle Last Candace Hawn Hawn			13e. STREET AND NUMBER 403 Clayborn Avenue		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 578-10-5333-8		17. INFORMANT Grady Hefner			ADDRESS Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary insufficiency; DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery heart disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE BEIDEN R. REAP		EXAMINER'S NAME (Type) BEIDEN R. REAP M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED Nov. 1, 1968
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE Nov. 4, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince George County, Md.		
24. FUNERAL DIRECTOR Warner E. Humphrey, Inc.				25a. REC'D BY REGISTRAR NOV 7 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16111

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16120

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH				2b HOUR	
Ralph		B.		Heinze				<input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> Nov. 24 1968				12 AM	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)		7 IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD				2d HOUR	
Male	W	Sept. 3, 1951		17 YRS		MONTHS DAYS HOURS MIN 17 YRS		Month Day Year Nov. 24 1968				8 AM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH							
Colorado		U. S. A.				Montgomery						Md.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY							
Rockville		Cryle Terrace		Student									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residents before admission) STATE		13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS?		3e STREET AND NUMBER					
Md.		Mont.		Rockville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14232 Arctic Avenue					
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle	
Benjamin		Heinze		D.		Marie		Anderson					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS							
No		561-84-4271		Parents		James							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>4309</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) <u>Rupture of Berry Aneurysm</u> stating the underlying cause <u>last.</u> DUE TO, OR AS A CONSEQUENCE OF (c)												Sudden	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
		HOUR A.M. P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No				City or Town		County		State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>													
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		John S. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED		Nov/25/1968	
EXAMINER'S NAME (Type)		John S. Ball		Bether, A. J.		ADDRESS (Street, city, town, or county)							
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)			
Burial		11/27/68		Tockville		Rockville		Montg.		Md.			
24 FUNERAL DIRECTOR		17 ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE							
Tyson Wheeler Funeral Home		Rockville, Md.		DATE NOV 27 1968		J. Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These pages remove carbon papers, (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16118

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16126

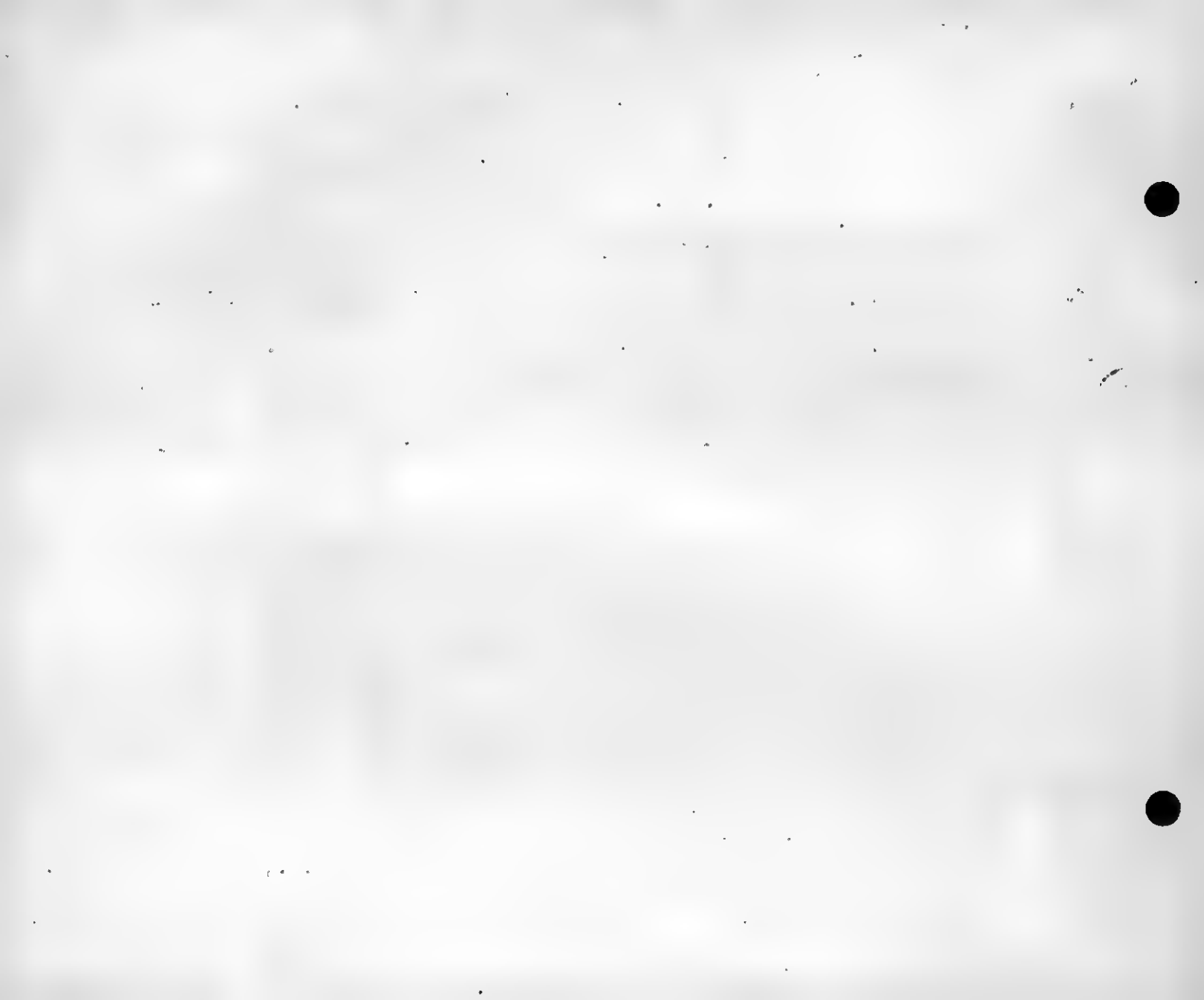
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Patricia A Heuser</i>			2a. DATE OF DEATH Month <i>Nov</i> , Day <i>24</i> , Year <i>1968</i>			2b. HOUR <i>3:45</i> PM			
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>12/31/23</i>		6. AGE (In years last birthday) <i>44</i> YRS.		7. UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>New York</i>		7b. CIT. ZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY <i>homemaker</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>433 St. Lawrence Drive</i>	
14. FATHER'S NAME First <i>Harry F.</i> Middle <i>Schuchroeder</i> Last <i>Heuser</i>			15. MOTHER'S MAIDEN NAME First <i>Anne</i> Middle <i>Hopper</i> Last <i>Heuser</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i>		16b. SOCIAL SECURITY NO <i>102-20-4110</i>		17. INFORMANT <i>William Heuser</i>		Address <i>same as above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hepatic Insufficiency due to</i> <i>11/4X</i> DUE TO, OR AS A CONSEQUENCE OF, (b) <i>metastatic disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Cir. of left breast 4 1/2 yrs ago.</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>6 months</i> <i>4 1/2 yrs.</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>17</i>									
19a. DATE OF OPERATION <i>11/13/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>cystic (Bryn) disease of breast</i>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUT NOT CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>11/12/68</i> , 19 <i>68</i> , to <i>11/24</i> , 19 <i>68</i> , that (I) (we) saw the deceased alive on <i>11/24/68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Howard H. Strine MD</i>		DEGREE <i>MD</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>11/25/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Howard H. Strine, M.D.</i>		22e. ADDRESS <i>483C VEE St. N.W. D.C.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>11-29-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges, Maryland</i>			
24. FUNERAL DIRECTOR <i>M. Andrew Duvall</i>				ADDRESS <i>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</i>		25a. REC'D BY REGISTRAR <i>DEC 3 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First FRANK		Middle W.		Last HOGUE		2a. DATE OF DEATH Nov. Month 7 th Day 1968		
3 SEX Male			4 RACE White		5. DATE OF BIRTH 12/12/86			6 AGE (In years last birthday) 81 YRS.		2b. HOUR 10 AM	
7a. BIRTHPLACE (State or foreign country) Pa.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Potomac			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 10824 Rock Run Drive			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Accountant			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10824 Rock Run Drive		
14. FATHER'S NAME First Soloman			Middle F.		Last Hogue		15. MOTHER'S MAIDEN NAME First Ludia			Middle L. Last Evans	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			(If yes give year or dates of service) -----		16b. SOCIAL SECURITY NO 203 05 9809-A		17. INFORMANT Address Ephraim V. Hogue - son same item #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma with Pleural Effusion</u> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) -----											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/10</u> , 19 <u>56</u> , to <u>11/7</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Seymour Greenbaum, M.D.</u> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/7/68			
22d. PHYSICIAN'S NAME (Type) Seymour Greenbaum						22e. ADDRESS 1800 I St. N.W., Washington, D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 11/9/68		23c. NAME OF CEMETERY OR CREMATORY Hermon Church Cem.			23d. LOCATION (City or Town) (County) (State) Potomac, Montg., Maryland			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home 131 Rockville Pike Rockville, Md.						25a. REC'D BY REGISTRAR NOV 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
James Claggett Holland						November 18 1968			11:05 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER YEAR MONTHS DAYS	
Male		White		18 February 1901		67 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY
Maryland		USA				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		The Clinical Center, NIH				Business Executive			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Chevy Chase				3604 Shepherd Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Claggett S. Holland			Ella Martin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
No			Not Available			Bethesda, Maryland			
						The Medical Records, The Clinical Center,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory failure									3 hours
2040 DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis									2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Acute lymphocytic Leukemia									1 1/2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
2040									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
11/4/68		perforated viscus			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State					
22a. I certify that XX (this hospital) attended the deceased from 2 Nov. 1968 to 18 Nov. 1968, that (I) (we) last saw the deceased alive on 18 November 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above XX (we) (did) observe view the body after death.									
22b. SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. DATE SIGNED		22f. REGISTRAR'S SIGNATURE	
Brian Goodell M.D.		Brian Goodell, M.D.		The Clinical Center, National Institutes of Health, Bethesda, Maryland		18 November 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		11-20-68		Parklawn Cemetery		Rockville, Maryland			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
ROBERT A. PUMPHREY, Bethesda, Maryland				NOV 26 1968		Charles Judge			

1. The first of these is the fact that the

the second is the fact that the

the third is the fact that the

the fourth is the fact that the

the fifth is the fact that the

the sixth is the fact that the

the seventh is the fact that the

the eighth is the fact that the

the ninth is the fact that the

the tenth is the fact that the

the eleventh is the fact that the

the twelfth is the fact that the

the thirteenth is the fact that the

the fourteenth is the fact that the

the fifteenth is the fact that the

the sixteenth is the fact that the

the seventeenth is the fact that the

the eighteenth is the fact that the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First NORA			Middle AGNES			Last HOLLAND		
2a DATE OF DEATH			Month Nov.			Day 17			Year 1968		
3 SEX Female			4 RACE Cauc.			5 DATE OF BIRTH May 9, 1879			6 AGE (In years last birthday) 89		
7a BIRTHPLACE (State or foreign country) Ireland			7b CITIZEN OF WHAT COUNTRY? U. S.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Rockville			NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley Nur.Home			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Owner-Delicatessen- Retired			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland			13b COUNTY Montgomery			13c CITY OR TOWN Bethesda			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME Timothy Harrington			15 MOTHER'S MAIDEN NAME Ellen Sullivan			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? No			16b SOCIAL SECURITY NO 360-26-8796		
17 INFORMANT Daughter Evelyn Hoyt			Address Same as Item 13.			18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPOSTATIC PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ENDOMETRIAL CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>13 YEARS</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CHRONIC CYSTITIS WITH PYELONEPHRITIS</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> , 19 <u>68</u> , to <u>NOV. 16</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>NOVEMBER 15, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <u>Joseph D. Connor, M.D.</u>			22c. DATE SIGNED 17 NOV. 1968			22d. ADDRESS 9420 OLD GEORGETOWN RD. BETHESDA, MD 20814					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 11-20-68			23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery			23d. LOCATION (City or Town) (County) (State) Butte, Montana		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland						25a. FILED BY REGISTRAR NOV 20 1968			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

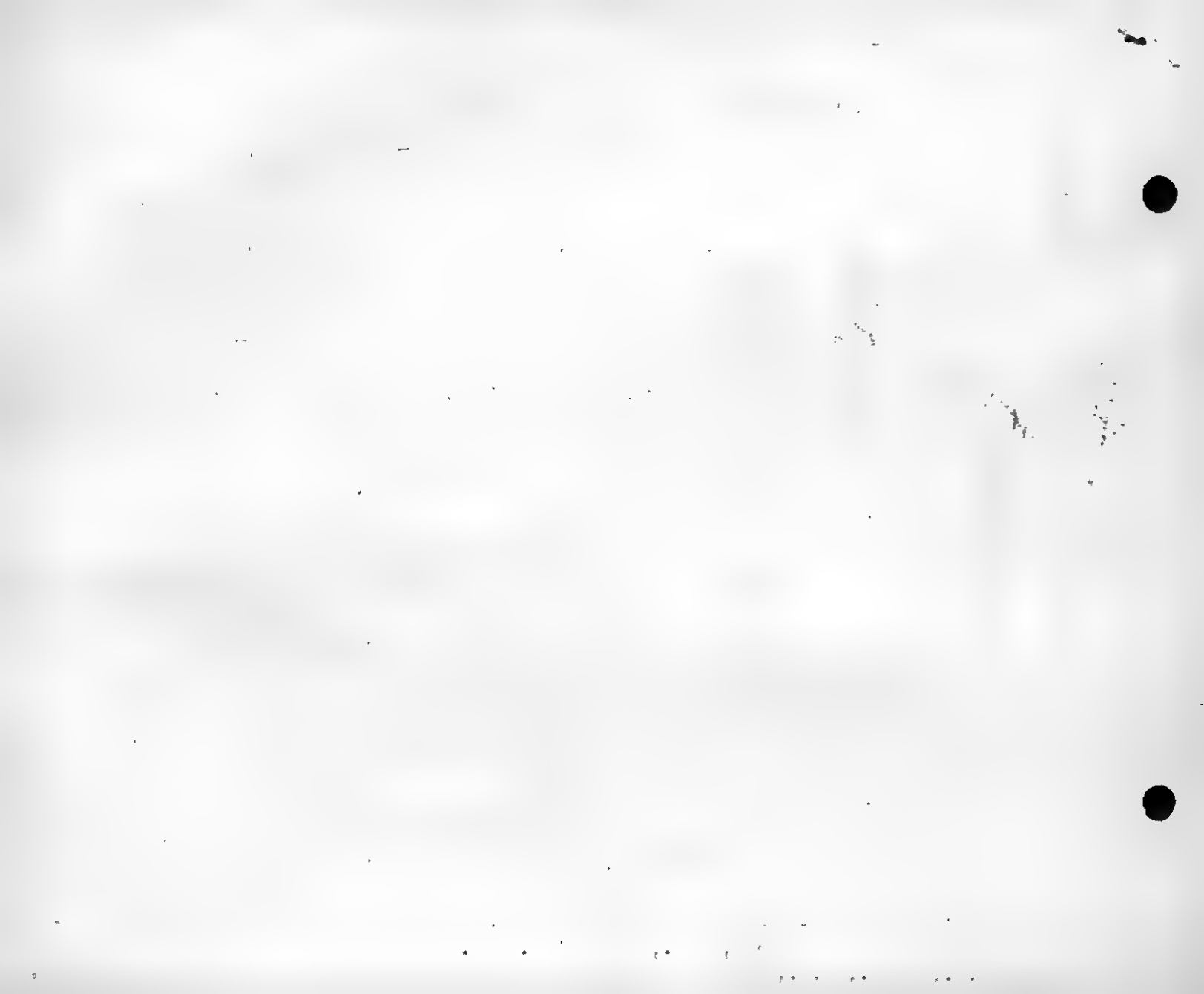
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161116										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										161120																																																											
1 DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																											
Margaret Louise Hollidge										Nov. 18 68										4:20 am																																																											
3. SEX										4 RACE										5 DATE OF BIRTH										6 AGE (In years last birthday)										7 IF UNDER 1 YEAR										8 IF UNDER 24 HRS.																													
Female										White										3-16-13										55 YRS.										MONTHS										DAYS										HOURS										MIN.									
7a BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																																																	
D.C.										USA																				Montgomery																																																	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
Olney										Montgomery General Hospital										Homemaker																																																											
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																																							
Maryland										Montgomery										Olney										YES <input type="checkbox"/> NO <input type="checkbox"/>										17521 Princess Ann Dr.																																							
14 FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																																					
David Heyser										Ernestine Krause																																																																					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/>										16b SOCIAL SECURITY NO.										17 INFORMANT										Address																																																	
										577-18-8373										Hospital Records										Olney, Md.																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART 1 DEATH WAS CAUSED BY.										IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF										2 yrs																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																				(b)										Adenocarcinoma of colon										3 yrs																																							
																				(c)																																																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																																															
MEDICAL CERTIFICATION																																																																															
19a DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																																											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f LOCATION Street or R.F.D. No. City or Town County State																																																											
22a. I certify that (I) (this hospital) attended the deceased from 11/11/68, to 11/18/68, that (I) (we) last saw the deceased alive on 11/17/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																																																																															
22b SIGNATURE										22c DATE SIGNED																																																																					
										11/18/68																																																																					
22d PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																																					
Dr. Charles Ligon										Sandy Spring, Md.																																																																					
23a B. BURIAL, CREMATION, REMOVAL (Specify)										23b DATE										23c NAME OF CEMETERY OR CREMATORY										23d LOCATION (City or Town) (County) (State)																																																	
Burial										11/20/68										Ft. Lincoln, Cem.										Colmar Manor, Md.																																																	
24 FUNERAL DIRECTOR										25a REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																											
Nalley's Funeral Home Inc., Maryland										ADDRESS Rt. Rainier, Maryland										DATE NOV 22 1968										x																																																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>16117</div> <div>CERTIFICATE OF DEATH</div> <div>16131</div>											
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH		2b HOUR			
Ferdinand			W.		Holmquist	Nov Month 15 Day 68 Year		11:25 PM			
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years birthday)		IF UNDER 1 YEAR			
male		Caucasian		4-3-1884		64 YRS		MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Sweden		Sweden				Montgomery Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Kensington			Kensington Gardens N.H.			Manager		Restaurant			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY, J.M.T.S?		13e STREET AND NUMBER		
D.C.			-		Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3817 Military Road N.W.		
4 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			(If yes give war or dates of serv. etc)			16b SOCIAL SECURITY NO		17 INFORMANT			Address
no						578-03-5597A		Miss Agnes Mathisen, Stepdaughter, same #1			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Disease</u>										Years	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
334x None											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
None						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
			HOUR A.M. Month Day Year P.M. <u>None</u>								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 15, 1967</u> to <u>Nov 15, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov 15, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED			DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					
<u>Arthur J. Anderson</u>			<u>Nov 15, 1968</u>								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
<u>Arthur J. Anderson</u>			<u>916 19th Street N.W. Wash D.C.</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<u>Burial</u>			<u>11-18-1968</u>		<u>Gate of Heaven Cemetery</u>		<u>Silver Spring, Mont., CO., Md</u>				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>Joseph Gawler's Sons, Inc., 5150 Wisc. Ave. N.W., Wash., D.C., 20016</u>						<u>NOV 22 1968</u>		<u>James J. Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16118												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												10000			
1. DECEASED NAME (Type or print) First Middle Last JOHN WARREN HOOO												2a. DATE OF DEATH Month Day Year 11 19 68						2b. HOUR 3 A M									
3. SEX MALE			4. RACE CAUCASIAN			5. DATE OF BIRTH 11/13/07			6. AGE (In years lost birthday) 61 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.													
7a. BIRTHPLACE (State or foreign country) D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.																		
10. CITY OR TOWN OF DEATH Silver Spring Md.				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Technician - radio & TV				12b. KIND OF BUSINESS OR INDUSTRY Self-employed															
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.				13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11550 Stewart Lane																	
14. FATHER'S NAME First Middle Last John Wood				15. MOTHER'S MAIDEN NAME First Middle Last Joanne Gooden Stark																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes unknown				16b. SOCIAL SECURITY NO. 214-32-9644				17. INFORMANT Mrs. Margaret Duffy, Silver Spring, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Severe Chronic Pulmonary Emphysema												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs ±															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (the hospital) attended the deceased from 1964 to 1968, that (I) (we) lost saw the deceased alive on 19 Nov 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE H.C. MAGARINI M.D.												22c. DATE SIGNED 11/19/68															
22d. PHYSICIAN'S NAME (Type) H.C. MAGARINI												22e. ADDRESS 50 W. Edmonston Dr., Rockville, Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE 11-21-1968				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland															
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				ADDRESS Sil. Spr. Md.				25a. REC'D BY REGISTRAR 11/19/68				25b. REGISTRAR'S SIGNATURE J. E. Jones															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
161119 Item#23a, FilmG406 11/21/68 km CERTIFICATE OF DEATH 16133											
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Catherine Elizabeth Hoover						11 Month 6 Day 68 Year			3:15 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS	
Female		Caucasian		8/1/1894			44 YRS.				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Washington, D.C.			USA						Montgomery Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Washington			University of Maryland			Domestic					
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INS. OF CITY LIMITS?		13e. STREET AND NUMBER	
D.C.			Montgomery			Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1109 P Street, N. W.	
14. FATHER'S NAME			15. MOTHER'S M.A.DEN NAME								
First Middle Last			First Middle Last								
Samuel Brown			Louise Campbell								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
No			577-58-1987								
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma, Left Breast</u>										1-2 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>170X</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION			City or Town County State		
						Street or R.F.D. No.					
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>68</u> , to <u>Nov. 6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
Stephen D. Protos, M.D.						11/6/68					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
STEPHEN D. PROTOS, M.D.						2025 R. ST., N.W. Wash. DC					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			11/11/68			Mt. Olivet Cemetery			Washington, D.C.		
24. FUNERAL DIRECTOR			25a. RECD BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
John T. Stewart, Jr.			DATE NOV 12 1968			Charles Judge					

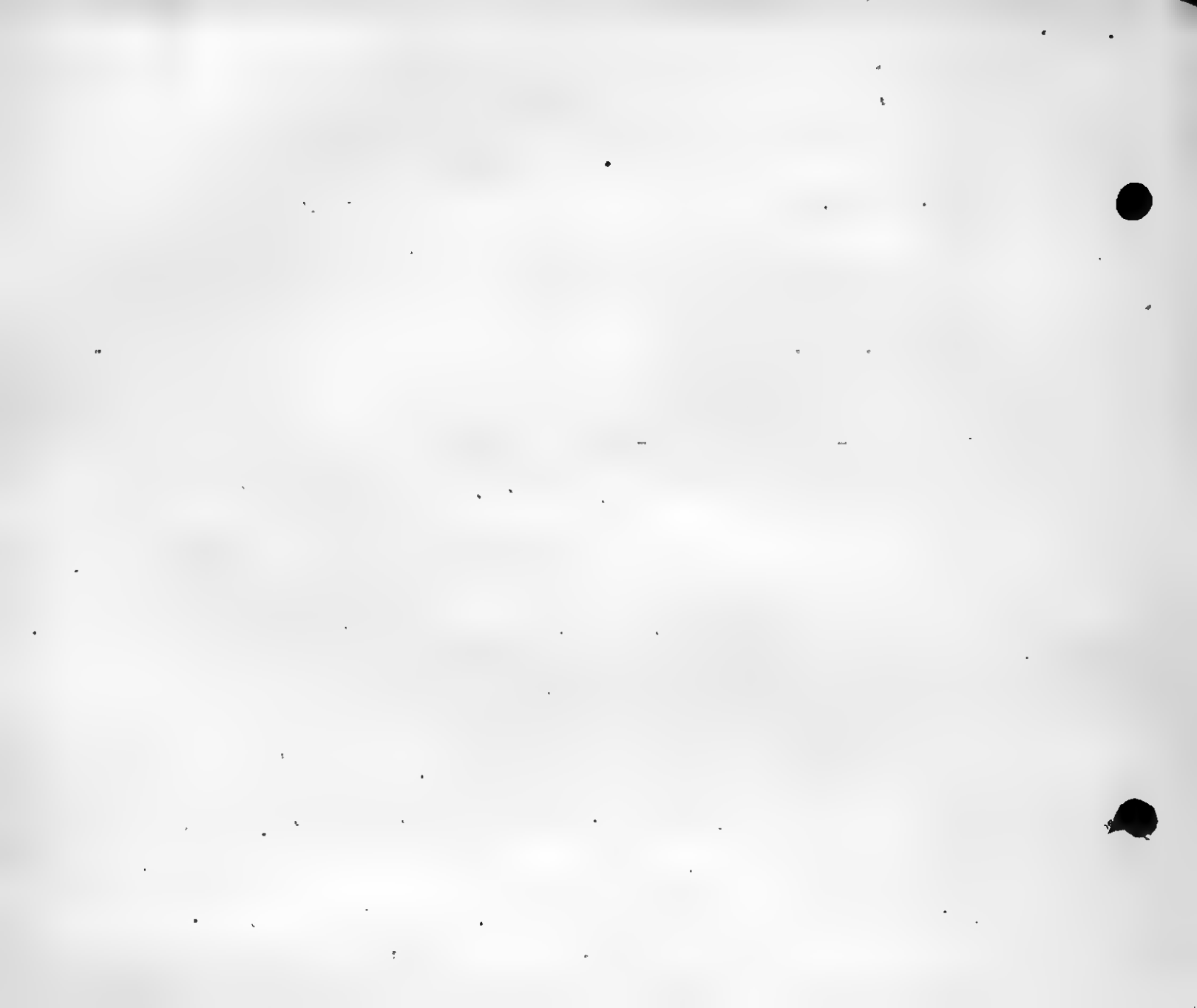
15120

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lrentwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crosvenor Nursing Home</u>		d. STREET ADDRESS <u>4500 - 33th Place</u>	
3. NAME OF DECEASED (Type or print) First <u>EDITH</u> Middle <u>HOOPER</u> Last <u>HOOPER</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>24</u> Year <u>1968</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/27/1882</u>
9. AGE (In years last birthday) <u>86</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ethan Lamb</u>		14. MOTHER'S MAIDEN NAME <u>Lila Mae Mussetter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>570-50-2027</u>	
17. INFORMANT <u>Chester T. Shelton (above address)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRCULATORY COLLAPSE</u> (b) <u>ARTERIO SCLEROTIC HEART DISEASE</u> (c) <u>ARTERIO SCLEROSIS, GENIC</u>			
DUE TO <u>1 hr</u> <u>5+ yrs</u> <u>10+ yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UREMIA, DEHYDRATION, UNDERNUTRITION</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>D.N.A.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u> </u>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB</u> , 19 <u>66</u> , to <u>PRESENT</u> , 19 <u> </u> , that I last saw the deceased alive on <u>11/23</u> , 19 <u>68</u> , and that death occurred at <u>2:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles Savarese, M.D.</u>		ADDRESS (Street, city or town, state) <u>1125 ROCKVILLE PIKE</u> DATE SIGNED <u>11/24/68</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES SAVARESE, M.D.</u>		<u>ROCKVILLE MARYLAND 20852</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/26/68</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>		ADDRESS <u>18 Mainier, Id.</u>	
24a. REC'D BY REGISTRAR <u>DATE NOV 29 1968</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1010.

1. DECEASED-NAME (Type or Print) <u>JAMES</u>		First Middle Last <u>J. Hopkins</u>		2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <u>Nov. 17 1968</u>		2b. HOUR <u>3:02</u> M <u>PM</u>	
3 SEX <u>male</u>	4 RACE <u>white</u>	5 DATE OF BIRTH <u>July 20, 1933</u>	6 AGE (in years and birthday) <u>35</u> YRS	7 UNDER 24 HRS MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD <u>Nov. 17</u> Day Year <u>1968</u>		2d. HOUR <u>4:23</u> M <u>PM</u>
7a. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md	
10. CITY OR TOWN OF DEATH <u>Rockville</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Hughes 705 + Montrose</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Foreman</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Machinist Shop</u>	
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE <u>Va.</u>		13b. COUNTY <u>Arlington</u>		13c. CITY OR TOWN <u>Arlington</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>1617 N. Edgewood Dr.</u>		14. FATHER'S NAME First Middle Last <u>Ben J. Hopkins</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>Mary Bullock</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	
16b. SOCIAL SECURITY NO <u>Korean War Not Avail.</u>		17. INFORMANT <u>Mrs. Mary B. Hopkins, Herminie, Penna.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Injuries - Severe</u>		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Trauma from Auto Accident</u>		DUE TO, OR AS A CONSEQUENCE OF (c)		<u>Sudden</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>8274</u>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <u>3 AM 11/17/1968</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Passenger in car went out of control Struck Tree</u>		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Hughes 705</u>		21f. LOCATION Street or R.F.D. No <u>705 + Montrose interchange - Rockville</u>		City or Town <u>Montgomery</u> State <u>MD</u>		22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <u>Nov. 17, 1968</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town or county) <u>Montgomery Co. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11/21/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Madison Union Cemetery, Madison, Westmoreland,</u>		23d. LOCATION (City or Town) (County) (State) <u>Penna.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 20 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Therese J. J...</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



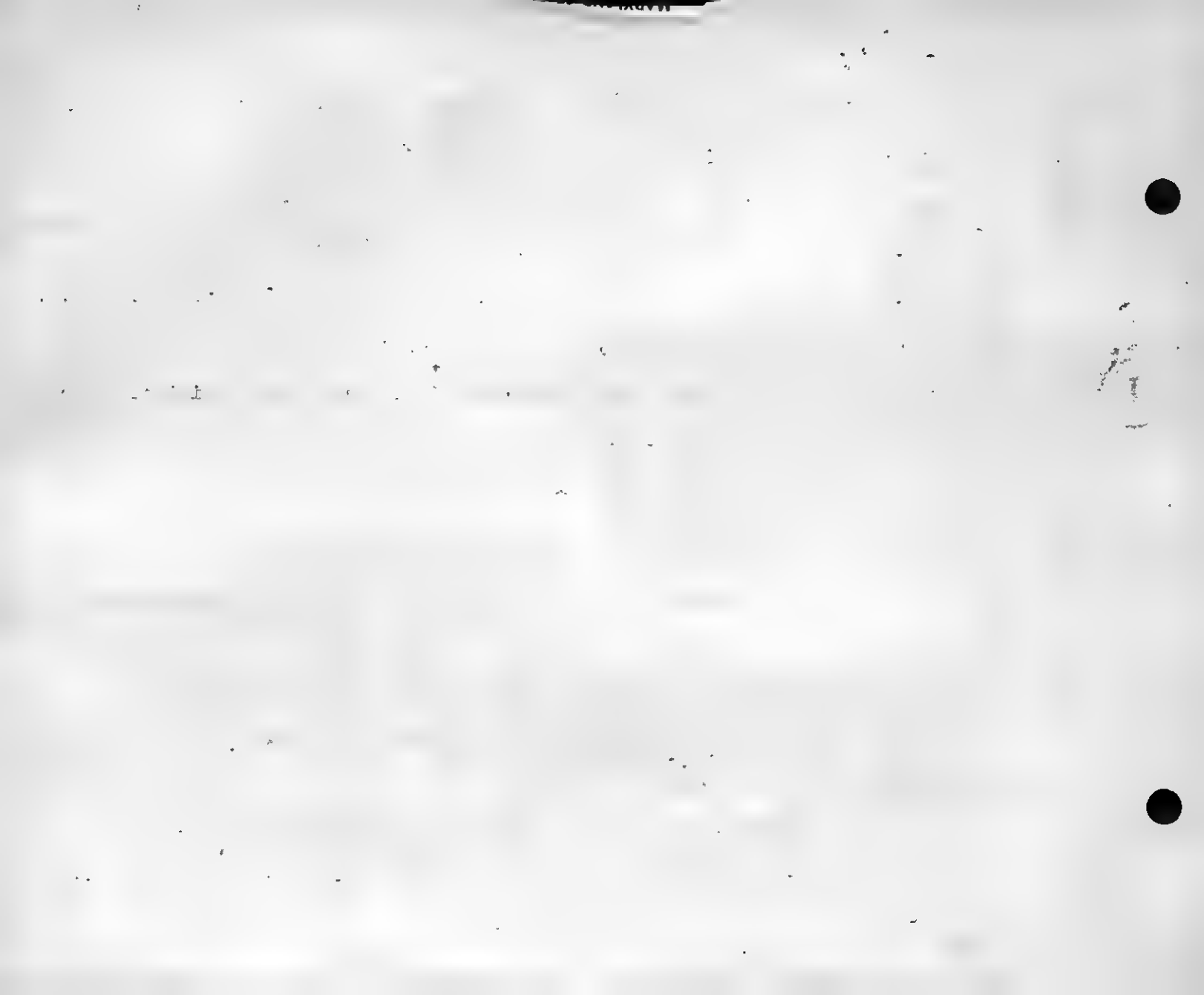
16122

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First: Viola Middle: (NMN) Last: Hopkins			2a. DATE OF DEATH Month: November Day: 12 Year: 1968		2b. HOUR OF DEATH 11:08 PM
3. SEX Female	4 RACE Negro	5. DATE OF BIRTH 11 September 1910		6 AGE (In years last birthday) 58 YRS	7. F UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN.
7a BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Domestic		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Washington, D.C. 13b. COUNTY	13c. CITY OR TOWN Washington, DC	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1715 Swann Street, N.W.		
14 FATHER'S NAME First: Moses Middle: Beverly Last: Dunlap	15 MOTHER'S MAIDEN NAME First: Mary Middle: Dunlap Last: Dunlap				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. (If yes give year or dates of service) Not Available	17 INFORMANT Bethesda, Maryland Address: The Medical Records, The Clinical Center			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia 2021 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Mycosis Fungoides DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 Weeks 3 Years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (X) (this hospital) attended the deceased from 2 October, 1968, to 12 Nov., 1968, that (X) (we) last saw the deceased alive on 12 November 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Clarence H. Brown, M. D.		22c. PHYSICIAN'S NAME (Type) Clarence H. Brown, M. D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. DATE 11-16-68		23b. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23c. LOCATION (City or Town) (County) (State) Prince George Md	
24. FUNERAL DIRECTOR John T. Rhines Company Funeral Home 3015 12th Street, N. E.		25a. REC'D BY REGISTRAR DATE: NOV 18 1968		25b. REGISTRAR'S SIGNATURE J. H. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 407
12-6-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15123

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1612

1. DECEASED NAME (Type or Print)			First Theresa			Middle Huang			Last			2a. DATE KNOWN OF EST DEATH MATED <input checked="" type="checkbox"/> 11-19 1968			2b. HOUR 12:10 AM		
3 SEX Female		4 RACE Oriental		5 DATE OF BIRTH 7-27-38		6 AGE (In years last birthday) 30 YRS		F UNDER YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month 11 Day 19 Year 68			2d. HOUR 12:10 AM		
7a. BIRTHPLACE (State or foreign country) Taiwan				7b. CITIZEN OF WHAT COUNTRY? Rep. of China				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery County Md					
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Psychologist				12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.				13b. COUNTY Montgomery				13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1220 East West Highway					
14. FATHER'S NAME First Chi Shiv Huang						15. MOTHER'S MAIDEN NAME First Sui-Pi Maria Chang											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b. SOCIAL SECURITY NO (If yes give war or dates of service)				17. INFORMANT ADDRESS Brother - Cheng-Schen Huang #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries DUE TO, OR AS A CONSEQUENCE OF (b) with internal hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8124																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 12:00 PM / 11/19 1968				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Deceased struck by auto while walking along highway.									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street				21f. LOCATION Street or R.F.D. No. Silver Spring				City or Town Montgomery				State Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Belden R. Respi				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED Nov. 19, 1968					
EXAMINER'S NAME (Type) BELDEN R. RESPI				M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) 2222 Wisc. Ave., N. W.					
23a. BURIAL, CREMATION REMOVAL (Specify) BURIED				23b. DATE 11-22-68				23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM.				23d. LOCATION (City or Town) WHEATON, MD.					
24. FUNERAL DIRECTOR James E. Dwyer				25a. REC'D BY REGISTRAR NOV 27 1968				25b. REGISTRAR'S SIGNATURE Charles Judge									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR A M
Steven			Leon	Hurwitz		November 25 1968			5:30
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. UNDER YEAR MONTHS DAYS HOURS MIN	
Male		White		22 October 1941		27 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Connecticut		USA				Montgomery Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			The Clinical Center, NIH			Student			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Connecticut					New Haven		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		232 Fountain Street
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Reuben					Hurwitz	Sonya			Saginer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT				
No			648-32-2541		The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia and edema									1 month
DUE TO, OR AS A CONSEQUENCE OF (b) Idiopathic hypertrophic subaortic stenosis									years
DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac arrest									1 month
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Postoperative cerebrovascular accident, third degree heart block									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
9/17/68 10/21/68		stenosis hypertrophic subaortic			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from Sept. 3, 1968, to Nov. 25, 1968, that (X) (we) last saw the deceased alive on November 25, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Charles L. McIntosh</i>					DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 25 November 1968
22d. PHYSICIAN'S NAME (Type) Charles L. McIntosh, M.D.					22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11/26/1968		23c. NAME OF CEMETERY OR CREMATORY Bnai Jacob Memorial Park		23d. LOCATION (City or Town) (County) (State) New Haven Connecticut			
24. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc.		24b. ADDRESS 9610 Rte. 1, Baltimore, Maryland		25a. REC'D BY REGISTRAR DATE NOV 26 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16125

CERTIFICATE OF DEATH

16130

1 DECEASED-NAME (Type or print) HERBERT First R Middle INGRAHAM Last			2a DATE OF DEATH Month Nov. Day 2 Year 1968			2b HOUR 12¹⁵ A	
3. SEX male		4 RACE W		5. DATE OF BIRTH 11/8/05		6. AGE (In years last birthday) 62 YRS.	
7a BIRTHPLACE (State or foreign country) NOVA Scotia		7b CIT ZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SEABOARD Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) EDITOR		12b KIND OF BUSINESS OR INDUSTRY Kepinger	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Bethesda		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 9305 LINDEN AVE		14. FATHER'S NAME First HERBERT Middle Wilson Last INGRAHAM		15 MOTHER'S MAIDEN NAME First Nellie Middle GREEN Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO. 4100		17. INFORMANT GERTRUDE INGRAHAM - WIFE		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4100							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes, clinical; hypertensive disease; nephrosclerosis cardiovascular							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDINGS, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that (1) (this hospital) attended the deceased from Aug , 19 1959 to 11/1 , 19 68 , that (1) (we) lost saw the deceased alive on Nov 1 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death							
22b SIGNATURE Alfred S Norton M.D.		22c DATE SIGNED 11/2/68		22d. ADDRESS 7710 Dewight Dr. Bethesda, Md			
22e. ADDRESS 7710 Dewight Dr. Bethesda, Md		22f. ADDRESS		22g. ADDRESS			
23a B. RIAL CREMATION, (Specify)		23b DATE Nov. 5 68		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Pr. Geo Md	
24. FUNERAL DIRECTOR Robert A Pumphrey		ADDRESS 3775 Wisconsin Ave Bethesda, Md		25a. RECD BY REGISTRAR NOV 6 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16126											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR		
Frank Herbert Jackson						Nov. 21			5:57 PM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 IF UNDER 1 YEAR		8 UNDER 24 HRS	
male		white		Sept 1 - 1892		86		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
D.C.		U.S.A.				Montgomery					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Bethesda			Suburban			Construction Engineer					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Montgomery			Cherry Chase			3704 Raymond St.		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
Frank H. Jackson			Mary Agnes Holbrook								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT			Address		
No.			579-46-6407			Donald F. Jackson			Same as above.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4177										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerosis, generalised										2 min.	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 4251										10 yrs +	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1) Rt. hemiplegia, progressive 2) arteriosclerotic disease											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1941 to 11/21/61, 1961, that (I) (we) last saw the deceased alive on Nov 19 1961, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE											
Stewart Clapp M.D.											
22c. DATE SIGNED 11/22/61											
22d. PHYSICIAN'S NAME (Type) Stewart Clapp M.D.											
22e. ADDRESS 5415 W. Cedar St. Bethesda Md.											
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Cremation			11-26-1968			Cedar Hill Crematory			Suitland, Prince Georges Co. Md.		
24 FUNERAL DIRECTOR											
Joseph Gawler's Sons, Inc., 5150 Wisc. Ave. Wash., D.C., 20016											
25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
DATE NOV 29 1968						J. Charles Judge					

MEDICAL CERTIFICATION

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

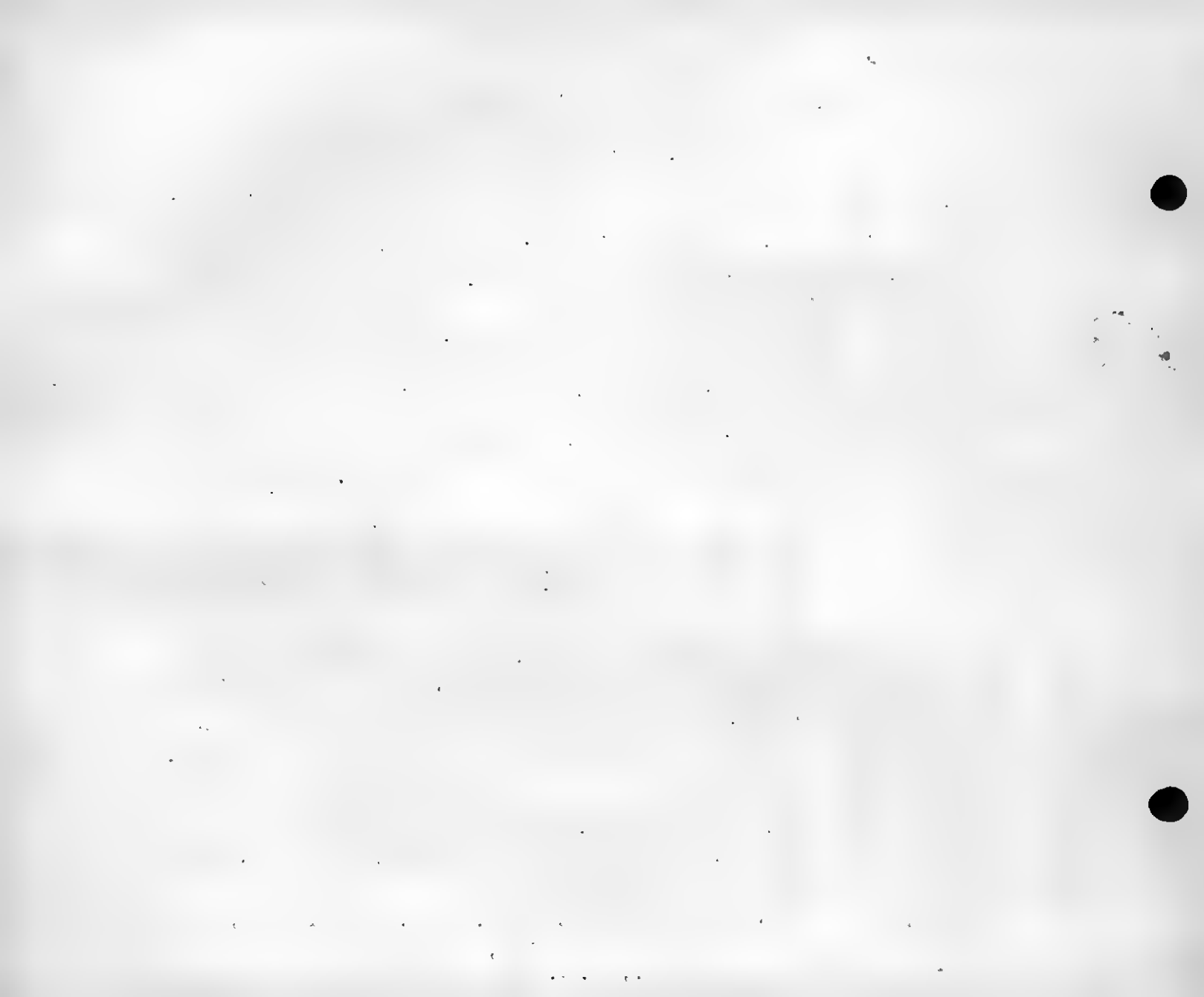
10127

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10141

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) MARION THERESA JACOBSON			2a. DATE KNOWN OF DEATH MATED 11-18-68			2b. HOUR 4 P.M.		
3. SEX Fe	4. RACE CAUC	5. DATE OF BIRTH 18 JUL 1926	6. AGE (In years last birthday) 42 YRS	7. UNDER 1 YEAR MONTHS 0 DAYS 0	8. UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD 11-18-68 Year 68 2d. HOUR 6:30 P.M.		
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 3205 KRONA DR				12a. JSJA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
13a. JSJA. RESIDENCE (Where deceased lived, if institution Residence before adm ssion) STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN SIL, SP.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3205 KRONA DRIVE
14. FATHER'S NAME First JOHN Middle McKEON Last McKEON			15. MOTHER'S MAIDEN NAME First ALICE Middle CARILLION Last CARILLION					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO 384-20-3783			17. INFORMANT Wm J. Jacobson, same ADDRESS Husband		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxiation, due to								
DUE TO, OR AS A CONSEQUENCE OF (b) Carbon monoxide poisoning								
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Ethylism with Depression								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)								
19a. DATE OF OPERATION								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year 4-11-18-1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 2, Item 18) Deceased started car in closed garage and ran into it from the rear		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) Home			21f. LOCATION Street or RFD No Silver Spring, Montgomery, Md City or Town Montgomery County Montgomery State Md		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Belden R. Reed			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED Nov. 18, 1968		
EXAMINER'S NAME (Type) BELDEN R. REED, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, City or Town, or County)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 21 Nov 1968		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia		
24. FUNERAL DIRECTOR Rinaldi Funeral Home				ADDRESS 7400 Georgia Ave, NW Wash., D.C. 20012		25a. REC'D BY REGISTRAR NOV 21 1968		25b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16128

CERTIFICATE OF DEATH

1614

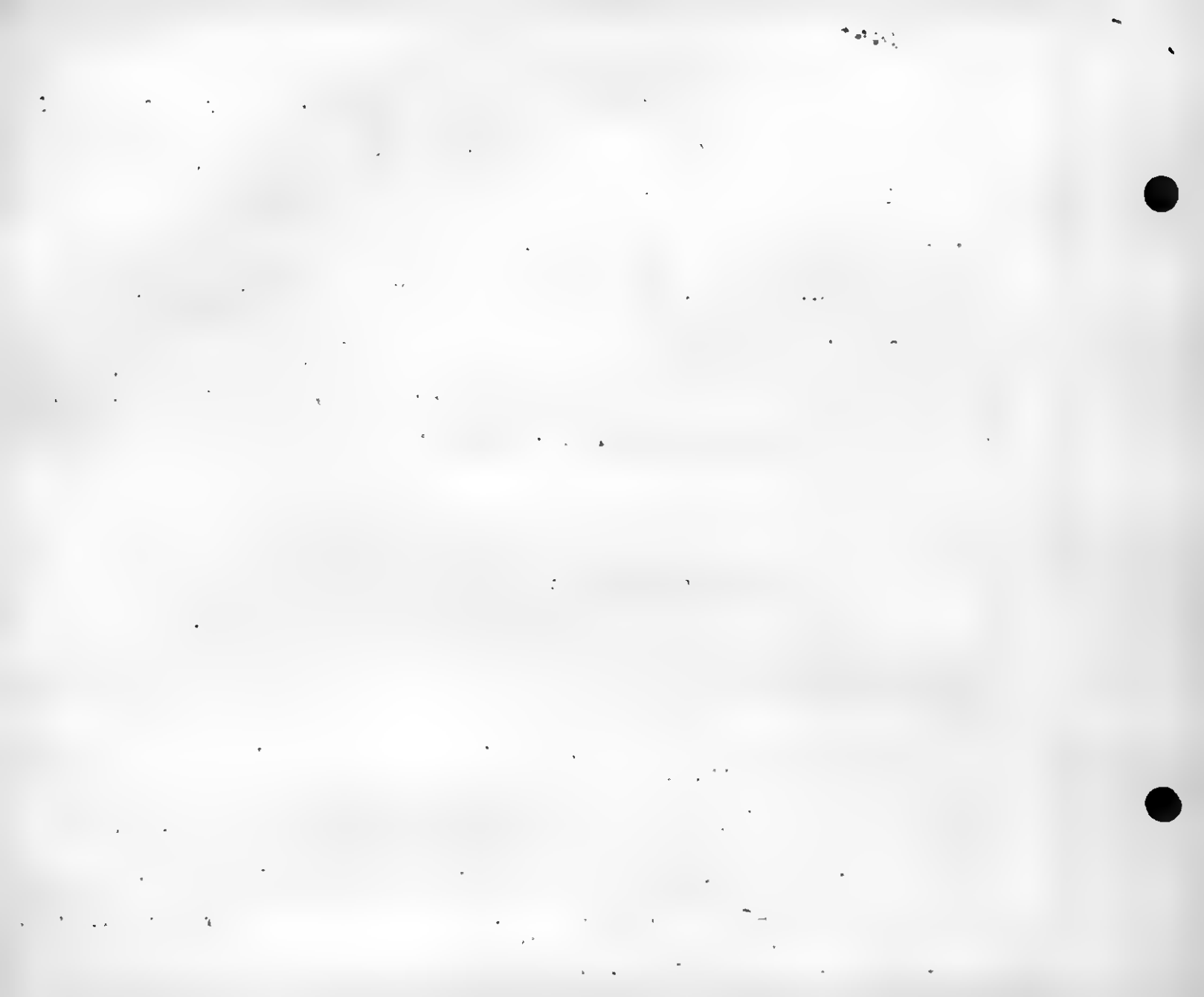
1 DECEASED NAME (Type or print) Lucienne M. JENKINS			2a. DATE OF DEATH Month November Day 26 Year 1968			2b. HOUR 11 P M	
3 SEX Female		4 RACE Cauc		5 DATE OF BIRTH October 25, 1935		6 AGE (In years lost birthday) 33 YRS	
7a BIRTHPLACE (State or foreign country) Paris, France		7b. CITIZEN OF WHAT COUNTRY? France		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a US-AL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Virginia		13b. COUNTY Woodbridge		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 71 Riverview Drive	
14. FATHER'S NAME First Middle Last Marcel Philippe			15 MOTHER'S MAIDEN NAME First Middle Last Reine Rousset				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT (husband) Address Woodbridge, Va. Franklin D. Jenkins, 71 Riverview Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) BILATERAL PNEUMONITIS 486 x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4. x RHEUMATIC HEART DISEASE							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (H) (this hospital) attended the deceased from 16 Sep , 19 68 , to 26 Nov , 19 68 , that (H) (we) last saw the deceased alive on 26 Nov , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>D. R. Fortan</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 27 Nov 68	
22d PHYSICIAN'S NAME (Type) D. R. FORTAN				22e ADDRESS NAVAL HOSPITAL BETHESDA, MARYLAND			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 29 Nov 68		23c NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington		23d LOCATION (City or Town) (County) (State) Virginia	
24 FUNERAL DIRECTOR Robert A. Pumphry		ADDRESS 7557 Wisconsin Ave. Bethesda, Maryland		25a RECEIVED BY REGISTRAR DEC 4 1968		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR		
Jeff			Lee	JENNINGS	NOV. 15 68		730A M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS		
Male		Caucasian		May 13, 1967		1 YRS		HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
California		USA				Montgomery Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Bethesda			Naval Hospital			N/A		N/A		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Pr. George		Laurel		YES		8202 Gorman Ave. Apt. 345	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
George F. Jennings			Verena Hanks							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT					
No			N/A		Laurel Address Md.					
					George F. Jennings, 8202 Gorman Ave. apt. 345					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hydrocephalus, congenital									18 months	
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b)										
Septicemia with diaphragmatic abscess										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M.								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION						
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from Oct. 10, 1968, to Nov. 15, 1968, that (X) (we) lost saw the deceased alive on Nov. 15, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.										
22b. SIGNATURE					22c. DATE SIGNED					
B. Jay BORTZ					Nov. 15, 1968					
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
B. Jay BORTZ					Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		11-19-68		Hickory Cemetery		Murray Co., Okla.				
24. FUNERAL DIRECTOR Robert A. Pumphrey					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Funeral Home, 7557 Wisconsin Ave., Bethesda					Nov 20 1968					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16130

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16144

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Luther			First Middle Last Nalen Johnson			2a. DATE OF DEATH 11 Month 19 Day 68 Year			2b HOUR 2 A M		
3. SEX Male			4 RACE White			5. DATE OF BIRTH 11/16/1903			6. AGE (In years last birthday) 65 YRS.		
7a. BIRTHPLACE (State or foreign country) Georgia			7b. CITIZEN OF WHAT COUNTRY? U.S.A			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret. red.) Mechanical Estimator			12b. KIND OF BUSINESS OR INDUSTRY Mechanics		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MD			13b. COUNTY Montgomery			13c. CITY OR TOWN Wheaton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 10820 Georgia Ave.			14. FATHER'S NAME First Middle Last Warren Johnson			15. MOTHER'S MAIDEN NAME First Middle Last Gertrude Fontaine					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO 416-01-5526			17. INFORMANT Mildred S. Johnson			Address Sil. Spr., Md. 10820 Georgia Avenue		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. 1419 IMMEDIATE CAUSE (a) Carcinoma of tongue DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1419									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral Thromboses											
19a. DATE OF OPERATION			19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1964 to NOV 19 1968 , that (I) (was) last saw the deceased alive on 18 NOV 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.											
22b. SIGNATURE Walter E. Goetz MD DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED NOV 19 1968		
22d. PHYSICIAN'S NAME (Type) WALTER E. GOOZH MD						22e. ADDRESS 8309 SHOREFIELD RD WHEATON MD					
23a. BURIAL CREMATION, (Specify)			23b. DATE 11-22-1968			23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery			23d. LOCATION (City or Town) (County) (State) Rockville Montgomery Md.		
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.						ADDRESS Sil. Spr. Md. 8434 Georgia Avenue			25a. REC'D BY REGISTRAR NOV 25 1968		
						25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

16131

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10110

1. DECEASED NAME (Type or print) BABY GIRL "A" JONES			2a. DATE OF DEATH Month Day Year November 2, 1968		2b. HOUR 1:52 PM
3. SEX FEMALE	4. RACE CAUC	5. DATE OF BIRTH November 1 1968		6. AGE (in years last birthday) YRS 22	IF UNDER 1 YEAR MONTHS DAYS 22 52
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. NAVAL HOSP (NNMC)		12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) NEWBORN		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY FT MEADE	13c. CITY OR TOWN FT MEADE	13d. INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 7342H Brownell Road
14. FATHER'S NAME First Middle Last JOHN M. JONES			15. MOTHER'S MAIDEN NAME First Middle Last RENA ANN WALKER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input checked="" type="checkbox"/> NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. NONE	17. INFORMANT HOSPITAL RECORDS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis, Massive Compatable with Hyaline 1701 DUE TO, OR AS A CONSEQUENCE OF Membrane Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 762.0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that XX (this hospital) attended the deceased from 1 November 19 68 , to 2 NOV. , 19 68 , that (I) (we) last saw the deceased alive on 2 November , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE G. H. Safley				22c. DATE SIGNED 3 November 1968	
22a. PHYSICIAN'S NAME (Type) G.H. SAFLEY LT MC USNR				22e. ADDRESS U.S. NAVAL HOSP. (NNMC) Bethesda, MD. 20014	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3 NOV 68	23c. NAME OF CEMETERY OR CREMATORY Baker Cemetery		23d. LOCATION (City or Town) (County) (State) Whitakers, No. Car.	
24. FUNERAL DIRECTOR W.W. CHAMBERS FUNERAL HOME		25a. REC'D BY REGISTRAR NOV 14 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16138

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16146

1. DECEASED-NAME (Type or Print)			First Norma			Middle Powell			Last Judd			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Month Day Year <input checked="" type="checkbox"/> 11 6 1968			2b. HOUR 1 A M		
3 SEX Fe.		4 RACE W.		5 DATE OF BIRTH March 10 1902		6 AGE (in years last birthday) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year Nov. 6 1968			2d. HOUR 10 A M		
7a. BIRTHPLACE (State or foreign country) Kentucky				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery Md					
10 CITY OR TOWN OF DEATH Bethesda.				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4977 Battery Lane				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Acct. Clerk				12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.					
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE Maryland				13b. COUNTY Montgomery				13c. CITY OR TOWN Bethesda.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4977 Battery Lane 204			
14. FATHER'S NAME First Middle Last William Powell						15. MOTHER'S MAIDEN NAME First Middle Last Ida May Nave											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO (If yes give way or dates of service) ** 579-01-6612				17 INFORMANT 11 Dale La. Wallingford, Penna. ADDRESS (Nephew) Raymond D. Lewis, Jr.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion. Acute -</u> <u>14104</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Arterio Sclerosis -</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4</u>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A M P M 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No		City or Town		County		State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JOHN G. BALL, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Montgomery Co., Md.				22b. DATE SIGNED NOV. 6, 1968									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 11/9/68		23c. NAME OF CEMETERY OR CREMATORY Maple Grove Cemetery				23d. LOCATION (City or Town) (County) (State) Nicholasville, Jess. Ky.							
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR DATE NOV 13 1968				25b. REGISTRAR'S SIGNATURE Charles Judge									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. This should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

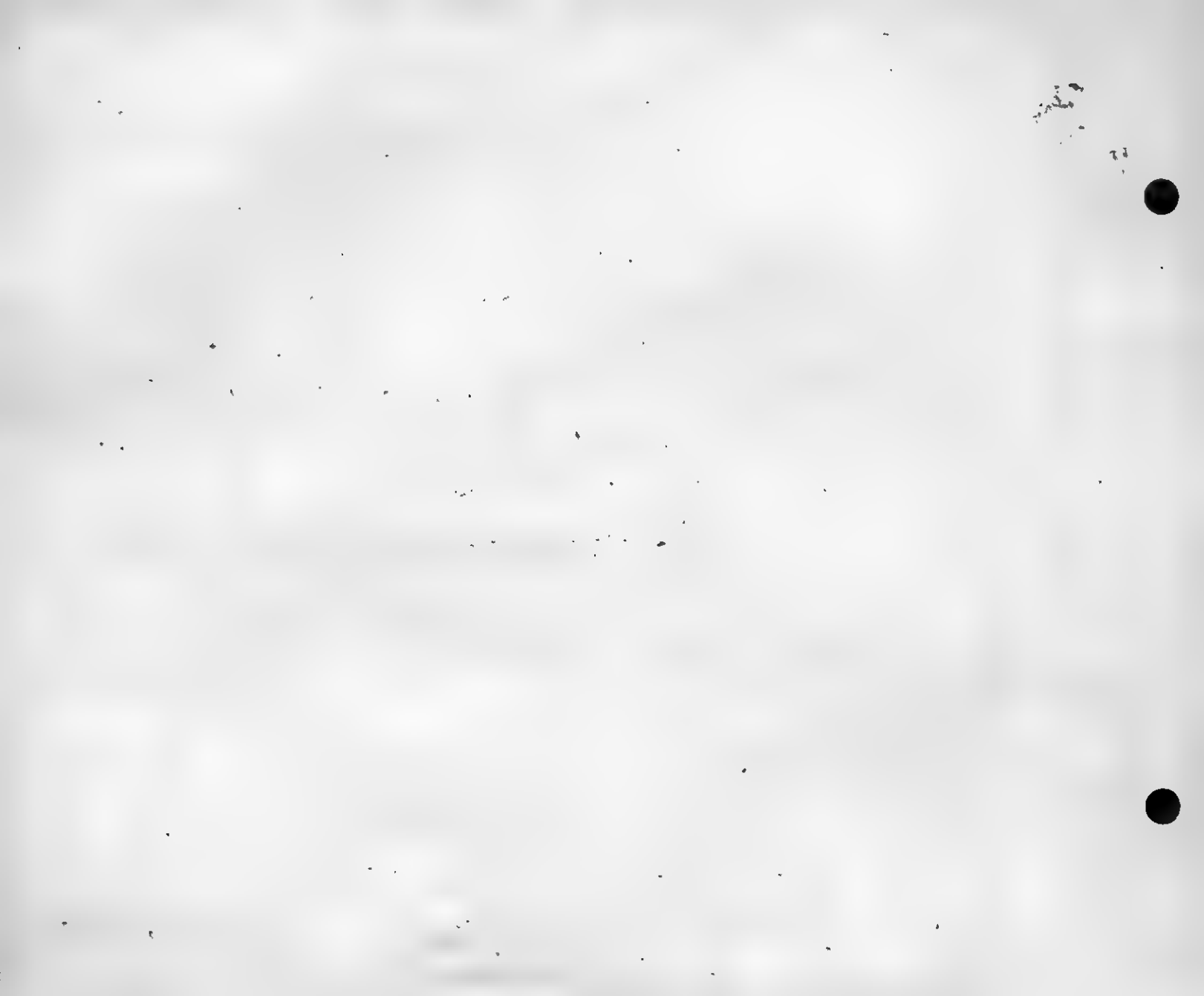
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16133

CERTIFICATE OF DEATH

16141

1 DECEASED-NAME (Type or print) <u>MARION ELIZA KAHLENT</u>			2a DATE OF DEATH Month <u>NOVEMBER</u> Day <u>18</u> Year <u>1968</u>			2b. HOUR <u>1:56 PM</u>			
3. SEX <u>FEMALE</u>		4 RACE <u>Cauc.</u>		5. DATE OF BIRTH <u>12-27-89</u>		6 AGE (in years last birthday) <u>78</u> YRS		IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u> HOURS <u> </u> MIN <u> </u>	
7a. BIRTHPLACE (State or foreign country) <u>LA.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>MONTGOMERY</u> Md			
10. CITY OR TOWN OF DEATH <u>TRIDEMA PARK</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>CAR HAVEN CARE HOME</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>MD.</u>		13b COUNTY <u>MONTGOMERY</u>		13c CITY OR TOWN <u>SILVER SPRING</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <u>702 GIST AVE.</u>	
14. FATHER'S NAME First <u>HERBERT</u> Middle <u>K</u> Last <u>BRADY</u>			15 MOTHER'S MAIDEN NAME First <u>MARY</u> Middle <u>K.</u> Last <u>DAVIS</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <u>no</u> or unknown <u> </u> (If yes give war or dates of service)		16b SOCIAL SECURITY NO. <u> </u>		17 INFORMANT <u>Marion D. Kahlent</u>		Address <u>Sil. Spr., Md.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia - terminal</u>									<u>6 days</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary thrombosis</u>									<u>2 yrs 4 months</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u>									<u>Unknown</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u> </u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u> P.M. <u> </u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 31</u> , 19 <u>61</u> , to <u>Nov 18</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>Nov 15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <u>Aaron H. Traum</u>		M.D. DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>November 18, 1968</u>			
22d. PHYSICIAN'S NAME (Type) <u>Aaron H. Traum, M.D.</u>		22e. ADDRESS <u>8237 Georgia Ave Silver Spring Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-21-1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges, Maryland</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Avenue</u>		RECD BY REGISTRAR <u>NOV 25 1968</u>		25b. REGISTRAR'S SIGNATURE <u> </u>			



16134

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16143

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with original. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED			Month Day Year			2b HOUR			
Louis			B			Kahn			11 21 68			8:30 AM			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD			
Male		White		1/17/11		57 YRS						Month Day Year 11 21 19 68 8:30 AM			
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH			
				USA								Montgomery Md.			
10 CITY OR TOWN OF DEATH:				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind at work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY			
Silver Spring				Holy Cross Hospital				paper salesman				paper			
13a USUAL RESIDENCE (Where deceased lived if institut an Residence before admission) STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Maryland				Montgomery								8425 Freyman Dr Chevy Chase			
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last											
Harry NMI Kahn				Goldie ? ?											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO.				17 INFORMANT				ADDRESS			
no				153-09-4959				wife Pauline				8425 Freyman Dr Chevy Chase Md			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>															
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Heart Disease</u>															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
4201															
19a DATE OF OPERATION						19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19						21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						22b DATE SIGNED			
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.						ADDRESS (Street, city, town, or county) <u>4219th St. N. W.</u>						NOV 21, 1968			
23a BURIAL CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)			
BURIAL				11-22-68				GEL WASH COM.				HATTOVILLE, MD.			
24 FUNERAL DIRECTOR						ADDRESS						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
GOLDENBERG FUNERAL HOME						4219th St. N. W.						DATE NOV 25 1968		<u>J. J. Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death-certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16135

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16149

1. DECEASED-NAME (Type or print) <i>Mabel</i>		First	Middle	Lost	2a. DATE OF DEATH Month <i>November</i> Day <i>14</i> Year <i>1968</i>		2b. HOUR M
3 SEX <i>Female</i>	4 RACE <i>Negro</i>	5. DATE OF BIRTH <i>January 6, 1882</i>			6 AGE (in years last birthday) <i>86</i> YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS
7a. BIRTHPLACE (State or foreign country) <i>PENNA</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Grosvenor Lane Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Silver Spring</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>1404 North Crest Drive</i>			
14. FATHER'S NAME <i>John</i>	First	Middle	Last	15. MOTHER'S MAIDEN NAME <i>Unknown</i>		First	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. <i>163-10-0948</i>		17. INFORMANT <i>Diana Luqueant</i>		Address <i>1404 North Crest Dr. Silver Spr., Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardiovascular Collapse</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Heart Disease</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>sev. hours</i> <i>many days</i> <i>many yrs.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Recent Myocardial Infarction</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (the hospital) attended the deceased from <i>10/31</i> , 19 <i>68</i> , to <i>11/14</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/12</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>G. H. Mitchell</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>11/14/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>George H. Mitchell, M.D.</i>		22e. ADDRESS <i>11125 ROCKVILLE PIKE, ROCKVILLE, MD.</i>					
23a. BURIAL-CREMATON, REMOVAL (Specify) <i>11-23-68</i>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <i>Eden Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Philadelphia, Penn.</i>	
24. FUNERAL DIRECTOR <i>Katney Funeral Home, 3831 Sec ave NW, Wash DC</i>				25a. RECEIVED BY REGISTRAR <i>NOV 18 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
16138 Items #1, 5, 6, & 8 Film G406 11/21/68												
1 DECEASED NAME (Type or print) <i>William R. S. Kennedy, Sr.</i>						2a DATE OF DEATH Month <i>Nov</i> Day <i>7</i> Year <i>1968</i>			2b HOUR <i>9:30</i> MIN <i>M</i>			
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>4/16/1911</i>		6 AGE (In years last birthday) <i>57</i> YRS		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		IF UNDER 24 HRS. HOURS <i>0</i> MIN <i>0</i>		
7a BIRTHPLACE (State or foreign country) <i>Ireland</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>			Md			
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>		12b KIND OF BUSINESS OR INDUSTRY						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Mont</i>		13c CITY OR TOWN <i>Rockville</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>15316 Narcessus Way</i>				
14 FATHER'S NAME First <i>Thomas</i> Middle <i>Kennedy</i> Last <i>Kennedy</i>				15 MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>Gudner</i> Last <i>Gudner</i>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Yes</i> (If yes give war or dates of service)				16b SOCIAL SECURITY NO <i>Unknown</i>		17 INFORMANT <i>Daughter</i>			Address <i>Same as above</i>			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Left Ventricle wall and Interventricular septum</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Arteriosclerosis, severe with</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>3rd degree block of ascending internal carotid artery</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4201</i>												
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medico-examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 19 <i>67</i> , to <i>11/7</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/7</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d,d) (d,d,d) view the body after death.												
22b. SIGNATURE <i>Robert C. Macon</i>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>11/7/68</i>				
22d. PHYSICIAN'S NAME (Type) <i>ROBERT C. MACON</i>						22e. ADDRESS <i>809 Viers Mill Rd, Rockville, Md.</i>						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <i>Nov 11, 1968</i>		23c NAME OF CEMETERY OR CREMATORY <i>Fairview Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Allentown, PA Lehigh Pa</i>						
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey Bethesda, Md.</i>						25a. REC'D BY REGISTRAR DATE <i>NOV 13 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

1615

16137

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) CLEVELAND KENNICUTT			2a. DATE OF DEATH Month 11 Day 25 Year 68			2b. HOUR 5:45 M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 5-25-85		6. AGE (In years last birthday) 83 YRS.	
7a. BIRTHPLACE (State or foreign country) N.Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY County Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Painter		12b. KIND OF BUSINESS OR INDUSTRY Gov't.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE md.		13b. COUNTY Montgomery S.S.		13c. CITY OR TOWN 9408 Biltmore Dr		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Philip Middle Kennicutt Last Schram			15. MOTHER'S MAIDEN NAME First Mary Middle Schram Last Schram				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. 220-44-7290		17. INFORMANT Mrs. Helen M. Kennicutt Address 9408 Biltmore Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4129 Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Emphysema ; Prostatism							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Nov 20, 1968 , to Nov 25, 1968 , that (I) (we) last saw the deceased alive on Nov 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bernard A. Fitzgerald MD				22c. DATE SIGNED 11-25-68		22d. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD	
22e. ADDRESS 217 UNIV. BLVD E, SILVER SPRING MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-29-1968		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C.	
24. FUNERAL DIRECTOR C. Glen Carter Warner E. Pumphrey, Inc. 8434 Georgia Avenue				25a. REC'D BY REGISTRAR DEC 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

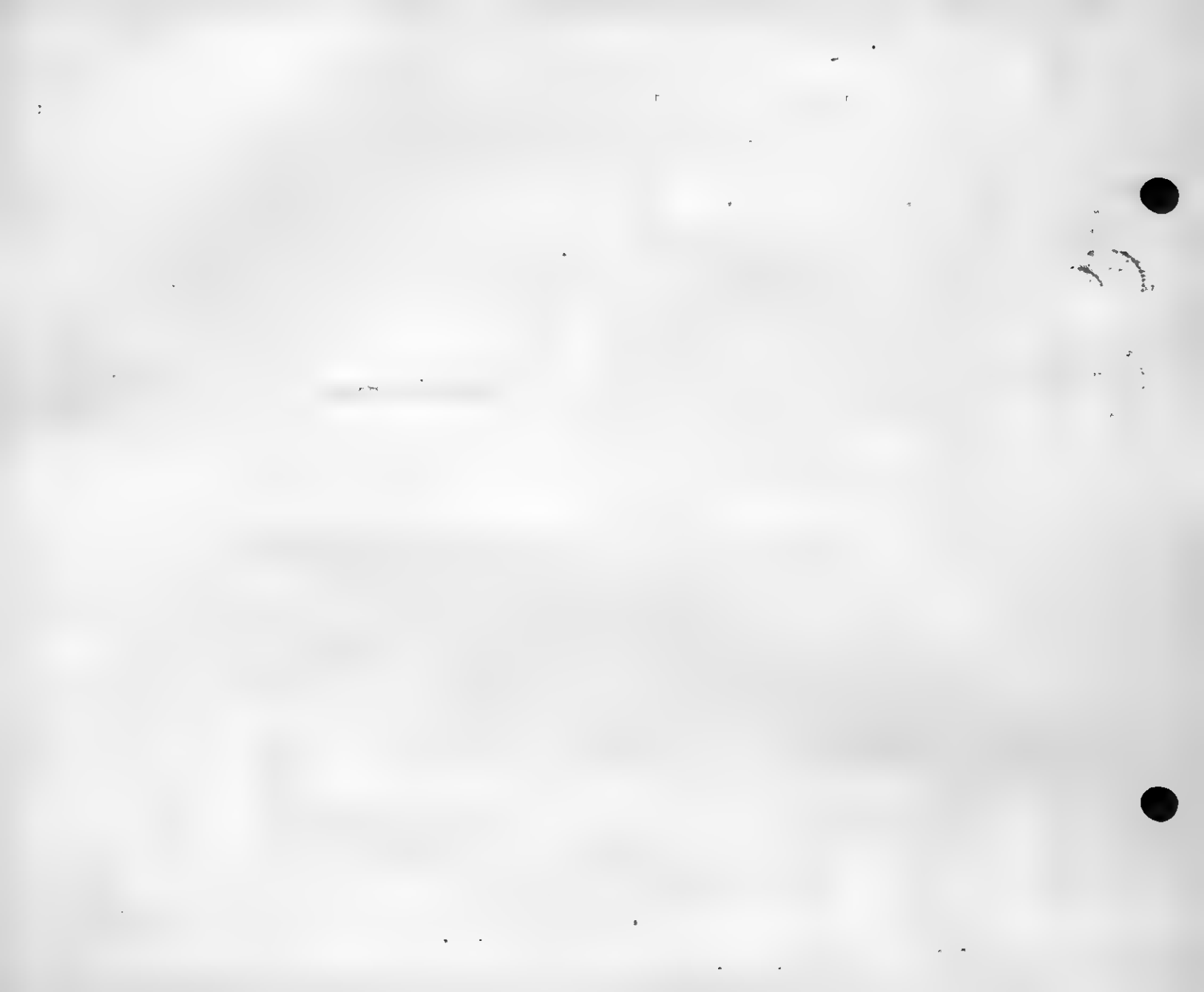
FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18&22a Film 407 Maryland State Department of Health
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
12-5-68
18138
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) First Middle Last Elmore Stanley King SR.			2a. DATE KNOWN OF DEATH Month Day Year 11-18-1968			2b. HOUR 4:19A	
3 SEX Male		4 RACE White		5. DATE OF BIRTH 10-26-11		6 AGE (In years last birthday) 57 YRS	
7a. BIRTHPLACE (State or foreign country) D. C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Takoma Park				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. & Hospital		12a. USUAL OCCUPATION (Kind of work done during most of work ng. life even if retired) Treasurer	
13a. U.S.A. RESIDENCE (Where deceased lived if institution Residence before admssion) STATE Md.				13b. CITY OR TOWN Silver Spring		13c. STREET AND NUMBER 10712 Tenbrook Drive	
14. FATHER'S NAME First Middle Last Edward Harvey King			15. MOTHER'S MAIDEN NAME First Middle Last May 9. Elmore				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO 577-48-2062		17. INFORMANT Daisy B. King ADDRESS Sil. Spr., Md. 10712 Tenbrook Drive		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute bilateral pulmonary embolus DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 465X							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on death resulted from. Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Keap			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED Nov. 18, 1968		
EXAMINER'S NAME (Type) BELDEN R. KEAP M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (City, Town, or County)		
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-21-1968		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		ADDRESS Sil. Spr. Md.		25a. REC'D BY REGISTRAR NOV 25 1968		25b. REGISTRAR'S SIGNATURE [Signature]	
8434 Georgia Avenue							



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-1-68
304M REV. 1-1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
JAMES			Edmund	KING	NOV. 28 1968			2-0 P M	
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE	WHITE		10/29/18			50 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Washington, D.C.		U.S.A.				MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
SILVER SPRING			Holy Cross Hospital			SUPERVISOR		TELEPHONE Co	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND			PRINCE GEORGE		ADELPHI		YES <input type="checkbox"/> NO <input type="checkbox"/>		2509 KILLDEER AVENUE
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
John			Marshall	King, Sr.	Mollie			Dornton	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT		Address	
YES AIR FORCE 1945-46			579-05-4930			Thelma J. King		Adelphi, Md.	
						THE DECEASED		2509 Killdeer Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) LEUCEMIA, LYMPHATIC									
DUE TO, OR AS A CONSEQUENCE OF									
(b) -									
DUE TO, OR AS A CONSEQUENCE OF									
(c) -									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
2040 NONE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (1) (this hospital) attended the deceased from July 6, 1954, to 11/28, 1968, that (1) (we) last saw the deceased alive on 11/28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death									
22b. SIGNATURE James A. Roberts, M.D.						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED NOV. 28, 1968	
22d. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS, M.D.						22e. ADDRESS 8907 GED. AVE. SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)			
Burial		11-30-1968		St. Lincoln Cemetery		Prince Georges, Maryland			
24. FUNERAL DIRECTOR		Address		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Warner E. Pumphrey, Inc.		8434 Georgia Avenue		DEC 5 1968		J. Charles Jones			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office (along with form PM-3) as soon as possible. It may be retained for your files.

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16140

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16154

1 DECEASED-NAME (Type or Print)		First RITA	Middle SUE	Last KING	2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 11 DAY 30 YEAR 1968		2b HOUR 5:30 PM
3 SEX Female	4 RACE White	5 DATE OF BIRTH 8-18-30	6 AGE (in years last birthday) 38 YRS	IF UNDER 1 YEAR MONTHS 11	IF UNDER 24 HRS DAYS 30	2c DATE PRONOUNCED DEAD MONTH 11 DAY 30 YEAR 1968	2d HOUR 5:30 PM
7a BIRTHPLACE (State or foreign country) PATTERSON, NJ		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10 CITY OR TOWN OF DEATH Olney, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Medical Librarian		12b KIND OF BUSINESS OR INDUSTRY Lenox Hill Hos	
13a USUAL RESIDENCE (Where deceased lived, if not in institution: Residence before admission to institution) New Jersey		13b COUNTY Patterson		13c CITY OR TOWN Patterson		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Louis King		Middle Sue		Last King		15. MOTHER'S MAIDEN NAME First Edith	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO. 154-22-4073		17 INFORMANT MRS. EDITH KING (Sister)		ADDRESS AS ABOVE	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest - 2500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acidosis and Diabetic Coma - DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden - 24 hr. 30 yr.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 260x							
19a. DATE OF OPERATION 260x		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John S. Ball		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED Dec. 1, 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12/2/68		23c. NAME OF CEMETERY OR CREMATORY Temple Emanuel		23d. LOCATION (City or Town) (County) (State) Saddle Brook, NJ	
24. FUNERAL DIRECTOR Adel Levine & Bros		ADDRESS 6010 Reisterstown Rd, Baltimore, Md		25a. REC'D BY REG STRAR DEC 3 1968		25b. REGISTRAR'S SIGNATURE Charles H. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

16141

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1015

1 DECEASED-NAME (Type or print) <i>George Victor Kissal</i>			2a DATE OF DEATH Month <i>Nov</i> Day <i>16</i> Year <i>1968</i>			2b HOUR <i>10:15 A</i>				
3 SEX <i>male</i>		4 RACE <i>white</i>		5. DATE OF BIRTH <i>8/1/10</i>		6. AGE (In years last birthday) <i>58</i>		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		
7a BIRTHPLACE (State or foreign country) <i>W. STON</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>				
10 CITY OR TOWN OF DEATH <i>Bethesda</i>			11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Unemployed</i>			12b KIND OF BUSINESS OR INDUSTRY <i></i>	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>MARYLAND</i>			13b CITY OR TOWN <i>Rockville</i>		13d INSIDE CITY (Y/N) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <i>257 CONGRESSIONAL LANE</i>			
14 FATHER'S NAME First <i>Victor</i> Middle <i>Kissal</i> Last <i>Kissal</i>			15. MOTHER'S MAIDEN NAME First <i>JULIE</i> Middle <i>(UNK)</i> Last <i></i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>no</i>			16b SOCIAL SECURITY NO <i>577-16-1166</i>		17. INFORMANT <i>4925 Washington St. Westbury Mass. 02132</i> <i>Victor B. Kissal - son</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thrombosis, abdominal aorta, acute</i>									<i>36 hours</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe generalized arteriosclerosis</i>									<i>8 years</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Myocardial Infarction X 2, CVA X 2 in past 8 years</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>1964</i> , 19 <i></i> , to <i>11/16/68</i> , 19 <i></i> , that (I) (we) last saw the deceased alive on <i>11/15/68</i> , 19 <i></i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Frederick S. Cannon MD</i>						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>11/16/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>FREDERICK S CANNON</i>						22e ADDRESS <i>7111 BLOOMINGDALE BLVD. ROCKVILLE MARYLAND</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			23b DATE <i>18 Nov. 1968</i>		23c NAME OF CEMETERY OR CREMATORY <i>FORT LINCOLN CEMETERY</i>			23d LOCATION (City or Town) (County) (State) <i>SUITLAND MD.</i>		
24. FUNERAL DIRECTOR <i>R. N. ADI FUNERAL HOME 7400 GEORGIA AVE. N.W.</i>						25a. REC'D BY REGISTRAR <i>RE 20017</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Jones</i>		
DATE <i>NOV 19 1968</i>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPT. OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16142											
16156											
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
Catherine A. Klein						Nov. 19 1968			4:29 P. M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		7. UNDER 24 HRS.	
Female		White		April 2, 1875		83 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Washington D.C.		U.S.				Montgomery Md					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Wheaton				Hendall's Hlks Nursing Home				HOMEMAKER		AT HOME	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MARYLAND				MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9122 ETON ROAD	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
James				Mary		KRAMER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO		17. INFORMANT					
No				577-66-0780		Earl Klein, 9122 Eton Road. S.D. Md					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY.											
IMMEDIATE CAUSE (a) Coronary thrombosis										21 hr.	
DUE TO, OR AS A CONSEQUENCE OF											
(b) Coronary atherosclerosis											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Generalized arteriosclerosis											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED											
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)											
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19											
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)											
21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.											
21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 10/27, 1967, to 11/19, 1968, that (I) (we) last saw the deceased alive on 11/19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE											
Benne G. Bender M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>											
22c. DATE SIGNED 11/19/68											
22d. PHYSICIAN'S NAME (Type)											
22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
23b. DATE 11/22/1968											
23c. NAME OF CEMETERY OR CREMATORY IVY HILL CEMETERY											
23d. LOCATION (City or Town) (County) (State) ALEXANDRIA VIRGINIA											
24. FUNERAL DIRECTOR											
25a. REC'D BY REGISTRAR											
25b. REGISTRAR'S SIGNATURE											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Donald William KNOX			2a DATE OF DEATH Month Nov Day 30 Year 1968			2b HOUR 4:50A M				
3 SEX Male		4 RACE Cauc		5 DATE OF BIRTH 11 Dec 1922		6 AGE (in years last birthday) 45 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN 		
7a BIRTHPLACE (State or foreign country) Canada		7b CITIZEN OF WHAT COUNTRY? Canada		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md				
10 CITY OR TOWN OF DEATH Bethesda			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) Canadian Navy			12b KIND OF BUSINESS OR INDUSTRY	
13a USAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Virginia			13b COUNTY FAIRFAX		13c CITY OR TOWN McLean		3d INS OF CITY, VIL, TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3e STREET AND NUMBER 1414 Laburnum St.	
14 FATHER'S NAME Hugh KNOX			15 MOTHER'S MAIDEN NAME Flora McCULLOUGH			17 INFORMANT Ann KNOX 1414 Laburnum St., McLean, Va.				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO			16b SOC AL SECURITY NO. NONE							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Malignant Melanoma 1729 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 1907 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Acute Pancreatitis										
19a DATE OF OPERATION 8-19-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute Pancreatitis			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that X (this hospital) attended the deceased from 6 August , 19 68 , to 30 November , 19 68 , that XX (we) last saw the deceased alive on 30 November , 19 68 , and that in XX (our) opinion death occurred on the date and hour and from the causes stated above, X (we) (did) (not) view the body after death.										
22b SIGNATURE Francis D. Keenan Jr.					22c DATE SIGNED 30 November 1968					
22d PHYSICIAN'S NAME (Type) Francis D. KEENAN JR. LT MC USN					22e ADDRESS Naval Hospital, Bethesda, Maryland					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 12-3-68		23c NAME OF CEMETERY OR CREMATORY Mount Royal Cemetery			23d LOCATION (City or Town) (County) (State) Montreal, Canada			
24 FUNERAL DIRECTOR W. W. CHAMBERS					25a REC'D BY REGISTRAR DEC 5 1968		25b REGISTRAR'S SIGNATURE Richard J. Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First <i>Clara</i>			Middle <i>Elizabeth</i>			Last <i>Kolb</i>		
2a. DATE OF DEATH			Month <i>November</i>			Day <i>29</i>			Year <i>1968</i>		
2b. HOUR <i>1 P.</i>											
3 SEX <i>Female</i>			4 RACE <i>White</i>			5 DATE OF BIRTH <i>Nov. 26, 1879</i>			6. AGE (n years last birthday) <i>89</i> YRS		
7a. BIRTHPLACE (State or foreign country) <i>Penn.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i>		
10 CITY OR TOWN OF DEATH <i>Silver Spring</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>801 Mc Coney Avenue</i>			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Penn.</i>			13b. COUNTY <i>Philadelphia</i>			13c. CITY OR TOWN <i>Philadelphia</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <i>466 W. Clapier Street</i>											
14. FATHER'S NAME			First <i>Martin</i>			Middle <i>- -</i>			Last <i>Holzhauser</i>		
15. MOTHER'S MAIDEN NAME			First <i>Louisa</i>			Middle <i>- - - -</i>			Last <i>Blocklinger</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service, <i>- - -</i>)			16b. SOCIAL SECURITY NO <i>187-36-0430</i>			17 INFORMANT <i>Dorothy K. Nutter</i>			Address <i>801 Mc Coney Ave. S.S.Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral vascular hemorrhage</i> <i>41</i> DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized art. sclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>- - -</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i> <i>10 yrs.</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>4221</i>											
19a. DATE OF OPERATION <i>- - -</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>- - -</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year <i>- - - 19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from <i>1960</i> , 19 <i>- -</i> , to <i>29 Nov, 1968</i> , that (1) (we) last saw the deceased alive on <i>29 Nov 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death											
22b. SIGNATURE <i>Ernest H. Harmon M.D.</i>						22c. DATE SIGNED <i>29 Nov 68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Ernest H. Harmon M.D.</i>						22e. ADDRESS <i>Colesville Road and Sligo Creek Pkwy.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>12-2-68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Westminster Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Bala Cynwyd Mont. Penna.</i>		
24. FUNERAL DIRECTOR <i>M. Andrew Duvall</i>						25a. REC'D BY REGISTRAR <i>DEC 5 1968</i>			25b. REGISTRAR'S SIGNATURE <i>John A. Judge</i>		
Warner E. Purphrey Inc., 8434 Ga. Ave. S.S., Md.											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
16145										
16159										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
Floyd E. Koontz						11 14 68		8:25 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
M		W		12-7-00		67 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
WEST VA.		U.S.				Montgomery Md.				
1d. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cherry Chase, Md			Bethesda Senior Spring Nursing Home			Mechanics rep.				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Montgomery		Cherry Chase		YES		9010 Spring Hill Lane	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
John W. Koontz			Edna ? ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
Yes			578-46-7725		Richard Crofford		4410 Noyes Ave Charleston, W. Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Myocardial failure										
4129 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) Coronary insufficiency										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Arteriosclerotic heart disease										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (1) (a)										
4. Strychnine										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> (If either, not by medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (1) (this hospital) attended the deceased from 1958, 19, to present, 19, that (1) (we) last saw the deceased alive on 11/13 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
John B. Umhau MD								11/14/68		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
JOHN B. UMHAU						8805 Conn. Ave. Cherry Chase, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		11-18-68		Columbia Gardens Cem.		Arlington Va.				
24. FUNERAL DIRECTOR						25a. RECD BY REG. STR.		25b. REG. STR.'S SIGNATURE		
Wilhelm Funeral Home 4308 Suitland Rd. S. E. Suitland, Md.						NOV 21 1968				

16140

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Lost	2a DATE OF DEATH Month / Day / Year		2b HOUR A	
JANE			MAXWELL	LARGENT	11 / 25 / 68		3:30M	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR MONTHS
Female		White		March 25, 1912		56 YRS		IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
Maryland		U.S.A.				Montgomery Md.		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Chevy Chase		7115 Edgevale Street		Secretary		Dept. Stor		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland		Montgomery		Chevy Chase				7115 Edgevale Street,
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle
Abram		L.	McCullough		Anna			Heck
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		7115 Edgevale Street		
No		***		577-01-7675		Mr. Paul E. Largent, Chevy Chase, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Sarcoma</u>								1+ months
1589								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) <u>Sarcoma of Omentum</u>								11 months
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
<u>Cerebral vascular thrombosis - 8 months</u>								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
3/5/1968		Sarcoma		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19						
21d INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State				
While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work								
22a. I certify that (I) (this hospital) attended the deceased from Jan. 9, 1968, to 11/25, 1968, that (I) (we) last saw the deceased alive on Nov. 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				22c. DATE SIGNED				
John E. Morris, M.D. DEGREE				11/25/68				
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
JOHN E. MORRIS, M.D.				1835 Eye St N.W.				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		11/27/68		Hill Crest Cemetery		Cumberland, Alleg. Md.		
24. FUNERAL DIRECTOR		7557 Wisconsin Ave.		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY, Bethesda, Maryland.				DEC 4 1968		f. Morris		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR	
Philbert Edward Laughlin						ESTIMATED <input checked="" type="checkbox"/> 11-29-68 19		7:00 AM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	2c DATE PRONOUNCED DEAD		2d HOUR
Male	White	10-6-1896/1893	75 YRS				Month 11 Day 29 Year 1968		9:55 AM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Missouri		U.S.A.				Montgomery Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Olney			DOA Montg. General Indep. Oil Industries			Oil Industries			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before adm ssion) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Texas			Midland Co. Midland					501 Scharbauer Drive	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
Patrick J. Laughlin			Mary Not known						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT			
No			464544252 A			Mrs. Phyllis Clay Washington, DC Medical Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									
20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			Nov. 29, 1968			
Belden R. Reep, M.D.			DEPUTY MEDICAL EXAMINER						
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Burial			Dec. 3, 1968			Rest Haven Mem. Park			Midland, Texas
24 FUNERAL DIRECTOR						25a. REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Warner E. Pumphrey, Inc. 8434 Ga. Ave. Sil Spg. Md.						DEC 5 1968		J. Charles Judge	

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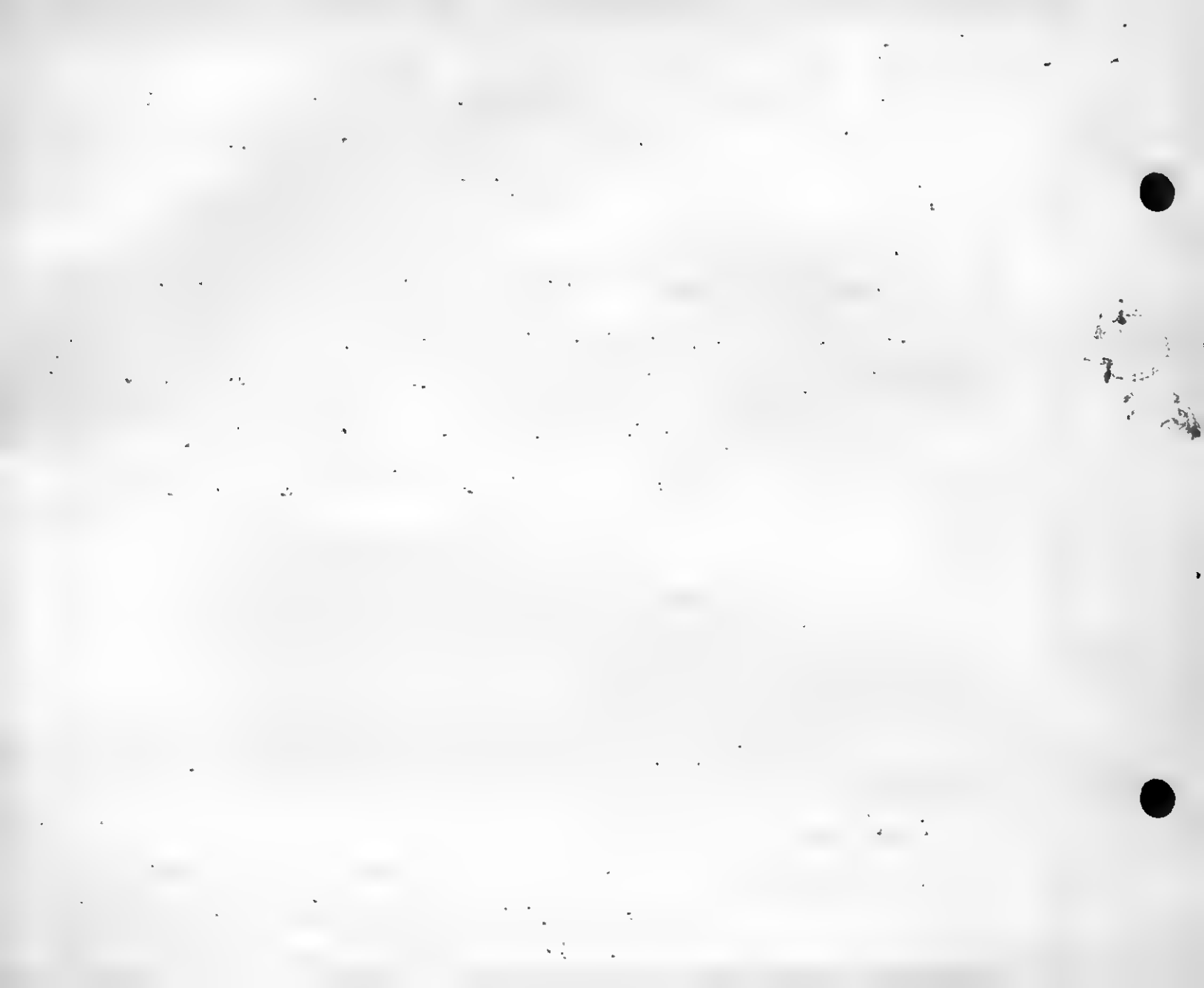
16148

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Gertrude E. Lederer			2a. DATE OF DEATH 11 Month 10 Day 68 Year		2b. HOUR 12 25 PM
3 SEX Female	4. RACE WHITE	5 DATE OF BIRTH 1-9-1884	6. AGE (In years last birthday) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) DC	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Wheaton	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wheaton Nurs. & Home	12a USUAL OCCUPATION (Kind of work done during most of working life) HOUSEWIFE	12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md.	13b COUNTY MONTG.	13c CITY OR TOWN WHEATON	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 12713 FLAK ST.	
14. FATHER'S NAME First Middle Last LOUIE C. HEITMULLER	15 MOTHER'S MAIDEN NAME First Middle Last EMILY W (UNK)	16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give branch and service) NEVER			
16b SOCIAL SECURITY NO. 578-10-8121B		17 INFORMANT ELIZABETH A. MILLISON Address			
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause last. Acute Coronary Insufficiency Arteriosclerotic Heart Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from May, 1960, to July, 1968, that (I) (we) last saw the deceased alive on Nov. 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Belden R. Reap, M.D.	22c. ADDRESS Wheaton, Md.	22d. DATE SIGNED Nov. 10, 1968	22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE 11-13-1968	23c. NAME OF CEMETERY OR CREMATORY GEO. WASH. MEMORIAL CEM.	23d. LOCATION (City or Town)	(County)	(State)
24. FUNERAL DIRECTOR W.W. CHAMBERS - 1400 CHAPIN ST. NW	25a REC'D BY REGISTRAR DATE NOV 14 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

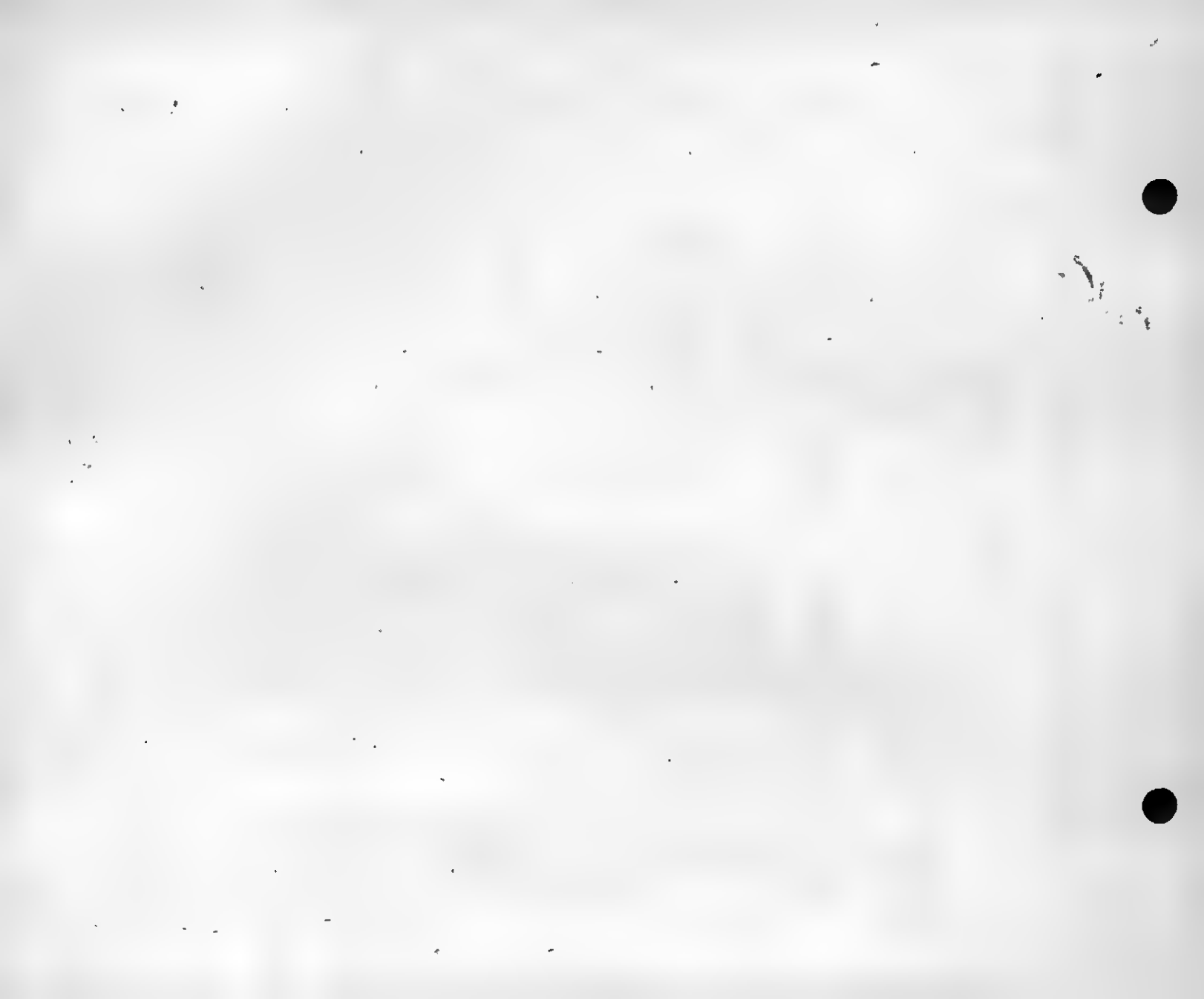
Item 6 Film 406 11/13/68 kk MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16149 16163									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last Charles Loomis LEE					2a. DATE OF DEATH Month Day Year Nov. 2 68			2b. HOUR 730P M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH Feb. 25, 1902		6. AGE (in years last birthday) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U. S. Navy		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland		13b. COUNTY St. Mary's		13c. CITY OR TOWN Hollywood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Route 2, Box 315	
14. FATHER'S NAME First Middle Last Augustine L. Lee					15. MOTHER'S MAIDEN NAME First Middle Last Mary Richardson Hopkins				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, Yes		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address Hospital records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA AND CONGESTION</u> <u>400X</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SECONDARY TO THROMBO-EMBOLIA RIGHT LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>460X</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>460X</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that the (this hospital) attended the deceased from <u>Oct. 23, 1968</u> , to <u>Nov. 2, 1968</u> , that the (we) lost the deceased alive on <u>Nov. 2, 1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, the (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Peter T. Kirchner</u>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED Nov. 4, 1968		
22d. PHYSICIAN'S NAME (Type) PETER T. KIRCHNER					22e. ADDRESS Naval Hospital, Bethesda, Md.				
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE NOVEMBER 6, 68		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington, Arlington, Va.			
24. FUNERAL DIRECTOR Mattingly Funeral Home Leonardtwn, Maryland 20650					25a. REC'D BY REGISTRAR DATE NOV 6 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) EDNA			First K. Middle LEISTER Last			2a. DATE OF DEATH Month Nov. Day 28 Year 1968			2b. HOUR 2:30 M
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 8/31/81			6. AGE (In years last birthday) 87 YRS.		7. IF UNDER 1 YEAR MONTHS 87 DAYS 87 HOURS 87 MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md			
10. CITY OR TOWN OF DEATH SILVER SPRING			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 12921 OLD COLUMBIA PIKE			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housekeeper			12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN POTOMAC	13d. INSIDE CITY, HTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10911 CANDLELIGHT LANE (50N)	
14. FATHER'S NAME First JACOB Middle L. Last KEFAUVER			15. MOTHER'S MAIDEN NAME First MARY Middle MORRISON Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give year or dates of service) ***			
16b. SOCIAL SECURITY NO. NONE			17. INFORMANT LEISTER, RICHARD A.			Address POTOMAC, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) —									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 HRS. SEVERAL YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) SENILE PSYCHOSIS, MARKED.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from APRIL 9, 1968 , to NOV. 28, 1968 , that (1) (we) lost the deceased alive on APRIL 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James A. Roberts M.D.					22c. DATE SIGNED 11/28/68		22d. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS		
22e. ADDRESS 8907 GEORGIA AVE. SILVER SPRING, MD.					22f. ADDRESS 7557 Wisconsin Ave. Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/2/68		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Mausoleum		23d. LOCATION (City or Town) (County) (State) Bladensburg, Pr. Geo. Md.			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR DEC 4 1968		25b. REGISTRAR'S SIGNATURE [Signature]					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-1-68
30M REV 1-68

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) GORDON HOWARD LESTER, SR.		First Middle Last		2a. DATE OF DEATH Month Day Year 11-26-68		2b. HOUR 5:10 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1-6-04		6. AGE (in years last birthday) 64 YRS.	
7a. BIRTHPLACE (State or foreign country) N.Y.		7b. CIT ZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. & Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution a Residence before admission) STATE Md. COUNTY Mont.		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY (Lat. 157) YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 904 Jackson Ave.	
14. FATHER'S NAME First Middle Last Daniel Lester				15. MOTHER'S MAIDEN NAME First Middle Last Theresa Seiwert			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Dorothea Lester - Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis and vascular (b) ASCVD - DISSECTION DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 3 1/2
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If neither, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1-5-6, 19 , to 11-26, 1968 , that (I) (we) last saw the deceased alive on 11-20, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James Whitlock, M.D.				22c. DATE SIGNED 11-26-68		22d. PHYSICIAN'S NAME (Type) James Whitlock, M.D.	
23a. B. R. I. A. L. O. P. E. R. A. T. I. O. N. REMOVED (Specify)		23b. DATE Nov. 30, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Luke's		23d. LOCATION (City or town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Arthur Walters				25a. REC'D BY REGISTRAR 254 Carroll St		25b. REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

15152

10166

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card no. 1, page 2, and card 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) First Middle Last Lucille (NMN) Lewis			2a DATE OF DEATH Month Day Year November 2 1968			2b HOUR 10:17 PM			
3 SEX Female		4. RACE White		5. DATE OF BIRTH 11 October 1907		6. AGE (In years last birthday) 61 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Oklahoma		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Washington			13b. COUNTY Lyle		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Star Route 180		
14 FATHER'S NAME First Middle Last Elza Dugan			15 MOTHER'S MAIDEN NAME First Middle Last Texana (Unknown)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service) No			16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Bethesda, Maryland Address The Medical Records, The Clinical Center				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 11/60 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cryptococcal Meningitis DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks several months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1341									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 2 November 1968 , to 2 Nov. 1968 , that (X) (we) last saw the deceased alive on 2 November 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.									
22b. SIGNATURE John S. Sargent, MD				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3 November 1968			
22d. PHYSICIAN'S NAME (Type) John S. Sargent, MD.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL, SPECIES Burial		23b. DATE 11/4/68		23c. NAME OF CEMETERY OR CREMATORY Idabel		23d. LOCATION (City or town) (County) (State) Oklahoma			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home				ADDRESS 1351 Rockville Pike Rockville, Md.		25a. REC'D BY REGISTRAR DATE NOV 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16158

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16167

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Dean Tracy Lilly						ESTIMATED MONTH DAY YEAR			34 M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR MONTHS DAYS	8 UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD			2d HOUR		
M.	W.	JUNE 29, 68	YRS 4	MONTHS 17	HOURS	Month NOV Day 14 Year 1968			7 P M		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md		
Illinois		U.S.A				Montgomery					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Rockville			1001 Rockville Pike								
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Md.			Montgomery			Rockville			1001 Rockville Pike.		
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		
David J. Majzel			Lora Lilly						none		
17 INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Father - same - above # 13A						PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Anoxemia - I.C.D.</u>			Sudden.		
						7769 DUE TO, OR AS A CONSEQUENCE OF					
						(b) DUE TO, OR AS A CONSEQUENCE OF					
						(c) DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
7620											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL EXAMINER'S SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED					
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			Nov. 14, 1968					
John G. Ball			7935 Old George								
			Bethesda, Md.			ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial - Transit			11/16/68			Stern's Cemetery			Oakwood--Vernillion-- Ill.		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
Tyson Wheeler Funeral Home			1371 Rock. Pike Rockville, Md.			DATE NOV 18 1968			Charles Judge		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or Print)			First	Middle	Last		2a. DATE KNOWN OF ESTI DEATH MATED		Month	Day	Year	2b. HOUR PM
Chester			W	Little		11-16		19	68	3	40	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	April 25, 1890		78	MONTHS DAYS		HOURS MIN.		11 16		340	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				Md		
New York		U.S.A.				Montgomery						
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp. or give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
Silver Spring			2017 Luzerne Avenue			Retired Merchant			Hardware			
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Md.			Montgomery			Sil. Spr.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2017 Luzerne		
14 FATHER'S NAME			First	Middle	Last		15. MOTHER'S MAIDEN NAME			First	Middle	Last
Joseph			Little				unknown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS			
no			577-03-6720			Mrs. Victor Little			Sil. Spg. Md. 2014 Luzerne Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State								
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		Beldar R. Reap				M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		Beldar R. Reap						ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		8 Nov. 16, 1968		
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
								ADDRESS (Street, city, town, or county)				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)		
Burial		Nov 19, 1968		Cedar Hill Cemetery		Suitland,		Maryland				
24 FUNERAL DIRECTOR		25a REG'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE								
Warner E. Pumphrey, Inc.		NOV 20 1968		Charles Judge								
8434 Ga. Ave. Maryland												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

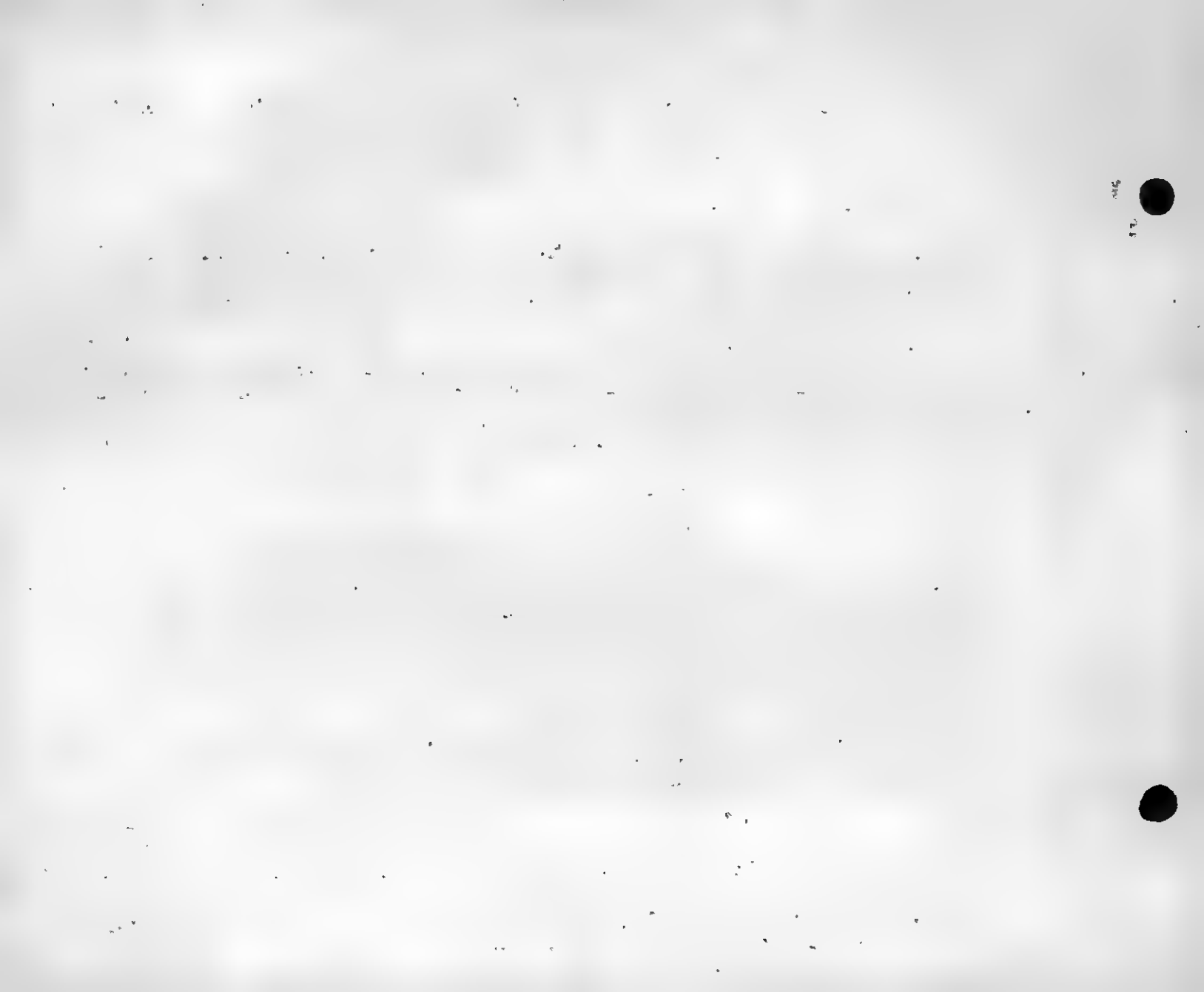
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print) <i>Kathryn Elizabeth Lloyd</i>						2a DATE OF DEATH Month <i>Nov</i> Day <i>10</i> Year <i>1968</i>			2b HOUR <i>3:45</i> PM			
3 SEX <i>female</i>		4 RACE <i>white</i>		5 DATE OF BIRTH <i>11-22-05</i>		6 AGE (in years last birthday) <i>62</i> YRS.		7 UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		7 UNDER 24 HRS. HOURS <i></i> MIN <i></i>		
7a BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		7b CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md						
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>				12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>Secretary</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Education</i>			
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <i>MD</i>				13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Rockville</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>913-Grandin Ave</i>		
14 FATHER'S NAME First <i>Louis</i> Middle <i>August</i> Last <i>Louis</i>				15 MOTHER'S MAIDEN NAME First <i>Lula</i> Middle <i></i> Last <i></i>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> no, or unknown <input checked="" type="checkbox"/>				16b SOCIAL SECURITY NO <i>no</i>		17. INFORMANT <i>Carolyn Elaine Lloyd</i> Address <i>As above</i>						
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of Breast</i> <i>174X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>undetermined</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>170X Portal Cirrhosis</i>												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. <i></i> Month <i></i> Day <i></i> Year <i>19</i> P.M. <i></i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f LOCATION Street or R.F.D. No <i></i> City or Town <i></i> County <i></i> State <i></i>						
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 1</i> , 19 <i>68</i> , to <i>Nov. 10</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Nov. 10</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE <i>Stanley M Bialek M.D.</i> DEGREE <i></i> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <i>Nov. 11, 1968</i>						
22d. PHYSICIAN'S NAME (Type) <i>Stanley Bialek</i>						22e ADDRESS <i>8218 Wisc. Ave. Bethesda, Md</i>						
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b DATE <i>11/13/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>			23d LOCATED ON (City or Town) <i>Silver Spring</i> (County) <i>Montg.</i> (State) <i> Md.</i>				
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i> ADDRESS <i>1351 Rockville e</i> <i>Rockville, Maryland</i>						25a. REC'D BY REGISTRAR <i>NOV 13 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR AM
James Franklin Long						November 17 1968			2:10 M
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS
Male		White		16 August 1929			39 YRS.		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Pennsylvania		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			The Clinical Center, NIH			Maintenance Foreman			Airlines Co.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
California					San Jose	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1053 Weyburn Lane	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Herman K. Long			Mary McFeely						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No --			188-20-5358		Bethesda, Maryland Lillian Long The Medical Records, The Clinical Center.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive endotracheal bleeding									30 minutes
DUE TO, OR AS A CONSEQUENCE OF (b) Tracheal pleural fistulae									2 weeks
DUE TO, OR AS A CONSEQUENCE OF (c) Postoperative pulmonary resection for carcinoma									9 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Clear cell carcinoma (pancoast) right upper lobe, clear cell carcinoma of kidney									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
10/24, 10/25, 11/7, 11/8			Pancoast tumor right upper lobe			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from 17 October, 1968, to 17 Nov., 1968, that (X) (we) last saw the deceased alive on 17 November 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
H. Bryan Neel, III, M.D.								17 November 1968	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
H. Bryan Neel, III, M.D.			The Clinical Center, National Institutes of Health, Bethesda, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		11-20-1968		Gate of Heaven Cemetery		Sil. Spr. Montgomery, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Warner E. Pumphrey, Inc.		8434 Georgia Avenue		Sil. Spr. Md.		NOV 25 1968		Pumphrey, Inc.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1617

16157

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Jennie B Longfelder		First Middle Last		2a DATE OF DEATH Month 11 Day 7 Year 1968		2b HOUR 8 15 P M	
3. SEX Female		4. RACE Caucasian		5 DATE OF BIRTH Sept 12, 1872		6. AGE (In years lost birthday) 96 YRS.	
7a BIRTHPLACE (State or foreign country) New York		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital or street address) Potomac Valley Nsg Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY At Home	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE VIRGINIA		13b. COUNTY Suffolk		13c CITY OR TOWN McLean		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 1439 Brookhaven Drive		14 FATHER'S NAME First Abraham Middle Blum Last Blum		15 MOTHER'S MAIDEN NAME First Unknown Middle Unknown Last Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (yes give war or dates of service)		16b SOCIAL SECURITY NO 147-36-9976		17 INFORMANT Edna S Wilson		Address 1439 Brookhaven Drive McLean VA	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral aneurysm Cerebral hemorrhage 412.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 422.1 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral aneurysm							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or RFD No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 9-9 , 19 68 , to 7-7 , 19 68 , that (I) (we) last saw the deceased alive on 5-20-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Stephen Jones		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 7 Nov 68	
22d PHYSICIAN'S NAME (Type) Stephen Jones		22e ADDRESS Rockville Md City, Rockville Md					
23a BURIAL, CREMATION Cremation		23b DATE Nov. 8, 1968		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d LOCATION (City or Town) (County) (State) Suitland Prgo Md	
24. FUNERAL DIRECTOR Robert A Pumphrey		ADDRESS 7557 Wisconsin Ave. Bethesda, Md		25a REC'D BY REGISTRAR NOV 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16158										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										1617									
1. DECEASED-NAME										2a. DATE OF DEATH										2b. HOUR									
First Middle Last										Month Day Year										HOUR MIN									
1. DECEASED-NAME (Type or print) <i>Harold T. Luskin</i>										2a. DATE OF DEATH Month <i>11</i> Day <i>25</i> Year <i>68</i>										2b. HOUR <i>4 P</i>									
3 SEX <i>Male</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>8-9-17</i>			6 AGE (in years lost birthgov) <i>51</i> YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN														
7a. BIRTHPLACE (State or foreign country) <i>New York</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i>																				
10 CITY OR TOWN OF DEATH <i>Bethesda</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Director - M.D. & Govt.</i>			12b. KIND OF BUSINESS OR INDUSTRY																				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>Mont</i>			13c. CITY OR TOWN <i>Bethesda</i>			13d. INSIDE CITY L.M.T.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>8800 Fernwood Rd</i>																	
14 FATHER'S NAME First Middle Last <i>- Luskin</i>										15. MOTHER'S MAIDEN NAME First Middle Last <i>-</i>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>										16b. SOCIAL SECURITY NO <i>375-16-6634</i>			17 INFORMANT <i>Wife</i> Address <i>Same as above</i>																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonitis, diffuse, bilateral viral</i> <i>486X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>492X</i>																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from <i>21 Nov, 1968</i> , to <i>25 Nov, 1968</i> , that (I) (we) last saw the deceased alive on <i>25 Nov, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <i>Horace W. Bernton, M.D.</i>										DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <i>11/26/68</i>													
22d. PHYSICIAN'S NAME (Type) <i>Horace W. Bernton, M.D.</i>										22e. ADDRESS <i>4743 Bradley Blvd Bethesda Md</i>																			
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>			23b. DATE <i>11-27-1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>			23d. LOCATION (City or Town) (County) (State) <i>Suitland, Prince Georges Co., Md</i>																				
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</i>										25a. REC'D BY REGISTRAR <i>NOV 29 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>																

16159

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16173

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) <i>Elizabeth Adams</i>				2a. DATE KNOWN OF DEATH Month <i>11</i> Day <i>21</i> Year <i>1968</i>				2b. HOUR <i>7:25</i> M	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>Dec 21 1875</i>		6. AGE (in years last birthday) <i>92</i> YRS		7. IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MONTGOMERY</i>			
10. CITY OR TOWN OF DEATH <i>Kensington</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Kensington Gardens Sanit Housewife</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>				13a. USUAL RESIDENCE (Where deceased lived, if institution, give name and address) <i>4104 Bel Pre Rd. Rockville Md</i>				13b. COUNTY <i>Rockville</i>	
13c. CITY OR TOWN <i>Rockville</i>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4104 Bel Pre Rd. Rockville Md</i>			
14. FATHER'S NAME First <i>Samuel</i> Middle <i>Ed</i> Last <i>Adams</i>				15. MOTHER'S MAIDEN NAME First <i>Jane</i> Middle <i>Magruder</i> Last <i>Adams</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16b. SOCIAL SECURITY NO <i>218 32 2499</i>		17. INFORMANT <i>Mrs. Leo Shandis Rockville, Maryland</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Belden R. Reap</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>Nov. 21, 1968</i>	
EXAMINER'S NAME (Type) <i>BELDEN R. REAP, M.D.</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, City or Town, County)			
23a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Nov. 23, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR <i>J.W. Lee Warner E. Pumphrey, Inc.</i>				4834 ADDRESS <i>Georgia Avenue Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 27 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)		First Irene		M ^{iddle} N		Last Manack		2a DATE OF DEATH Nov Month 24 Day 68 Year		2b HOUR 6 A M
3 SEX Female		4 RACE White		5 DATE OF BIRTH Jan, 18, 1903		6 AGE (In years last birthday) 65 YRS		IF UNDER YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) Oregon		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery				
10 CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 13741 Travilah Road		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Civil Service		12b KIND OF BUSINESS OR INDUSTRY U.S. Govt				
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md		13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY L.W. 1st YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 13741 Travilah Road		
14 FATHER'S NAME First Harvey M ^{iddle} E Last McCullough		15 MOTHER'S MAIDEN NAME First Ella M ^{iddle} E Last Owens								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give branch and dates of service)		16b SOCIAL SECURITY NO 271-07-2420-D		17 INFORMANT M. E. Ryan		Address 13741 Travilah Rd. Rockville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT										
DUE TO, OR AS A CONSEQUENCE OF										
(b) MULTIPLE ARTERIAL THROMBOSES										
DUE TO, OR AS A CONSEQUENCE OF										
(c) LYMPHOSARCOMA										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
2001 CHRONIC BLADDER INFECTION										
19a DATE OF OPERATION		19b CONDIT ON FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> not while <input type="checkbox"/> at work		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (the hospital) attended the deceased from 3/19 , 19 66 , to 11/24/68 , 19 68 , that (I) (we) last saw the deceased alive on 10/10/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Frederick Caldwell		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 11/25/68				
22d PHYSICIAN'S NAME (Type) Dr. Frederick Caldwell		22e ADDRESS Rockville, Maryland								
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 11-25-68		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d LOCATION (City or Town) (County) (State) Suitland d Pr. Geo. Md				
24 FUNERAL DIRECTOR Robert A Pumphrey		ADDRESS 7557 Wisconsin Ave Bethesda, Md.		25a REC'D BY REG. STRAR DEC 4 1968		25b REGISTRAR'S SIGNATURE Frederick Caldwell				



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 408
1-13-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16175

16161

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Andrew Broadbuss Marshall			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 11 - 24 1968			2b HOUR 5:55		
3 SEX Male	4 RACE White	5 DATE OF BIRTH Dec. 10, 1901	6 AGE (In years last birthday) 66 YRS	IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS HOURS _____ MIN _____		2c DATE PRONOUNCED DEAD Month 11 Day 24 Year 1968
7a BIRTHPLACE (State or foreign country) Washington DC		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Estimator		12b KIND OF BUSINESS OR INDUSTRY Supply Equip.	
13a USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 4001 Beverly Road
14 FATHER'S NAME First Clarence Middle W. Last Marshall			15 MOTHER'S MAIDEN NAME First Sallie Middle L. Last Broadbuss					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO (If yes give year or dates of service) 578-26-4165		17. INFORMANT ADDRESS Mrs. Ethel M. Marshall 40001 Beverly Rd. Rock				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple extreme injuries including DUE TO, OR AS A CONSEQUENCE OF (b) skull fracture and intracranial DUE TO, OR AS A CONSEQUENCE OF (c) hemorrhage, incurred in fall								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9010								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year HO. P.M. 12:05 P.M. 11-24 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1, or Part 2, Item 18.) Deceased, working about house, fell off ladder				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f LOCATION Street or R.F.D. No 4001 Beverly Rd. Rockville		City or Town Montg.		State Md.
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) Belden R. Reap, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED Nov. 24 1968		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 11/27/68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION (City or Town) (County) (State) Suitland Pr. Geo. Md.		
24 FUNERAL DIRECTOR W. Lee				ADDRESS Warner E. Pumphrey Inc. 8434 Ga. Ave. S.S., Md.		25a. REC'D BY REGISTRAR DATE NOV 29 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 134
30M REV 1-58

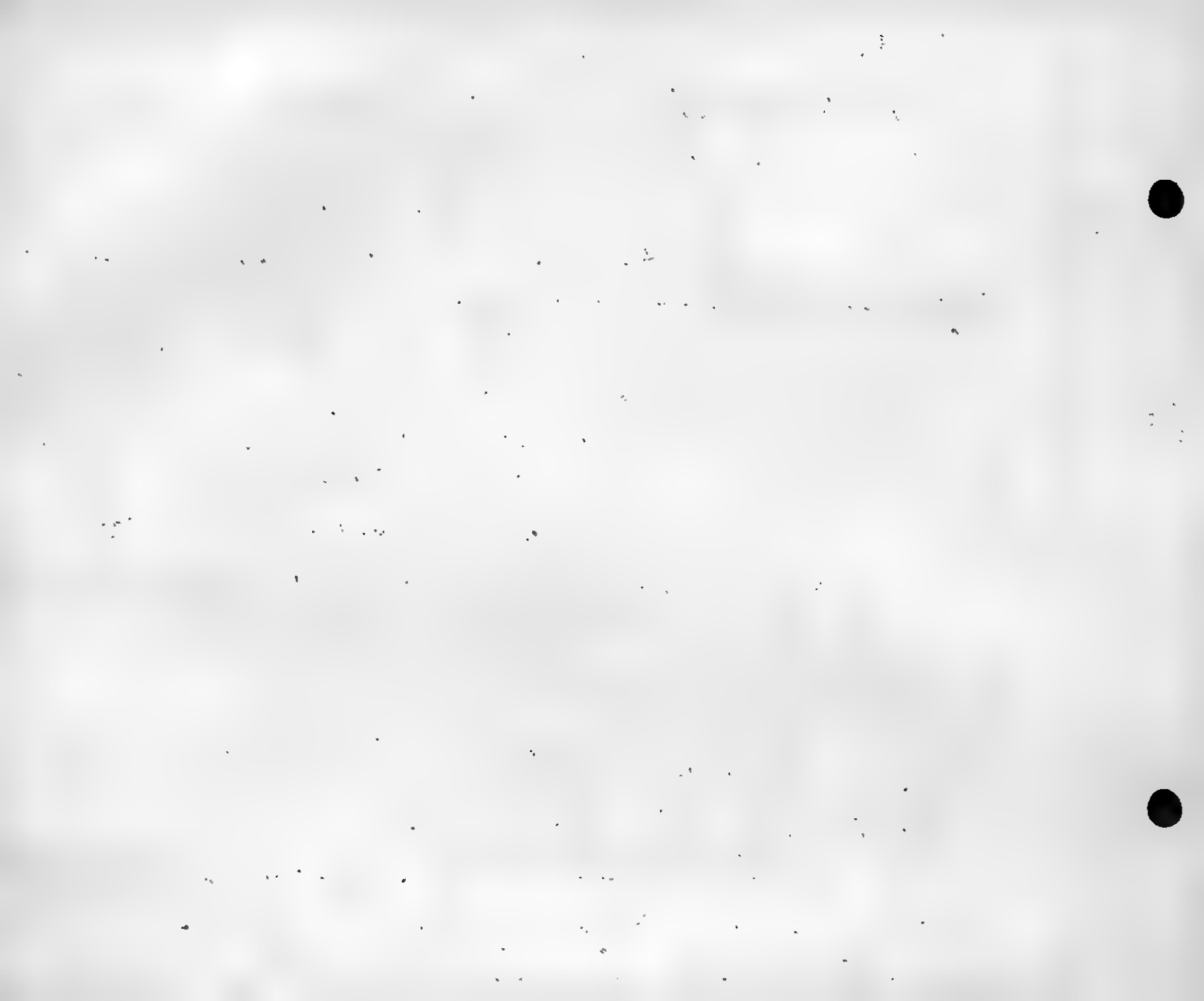
16162-

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16170

1. DECEASED-NAME (Type or print) MARTHA Woodard			First Middle Last			2a. DATE OF DEATH Month November Day 7 Year 1968			2b. HOUR 8:30 A.M.		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH August 20, 1879			6. AGE (In years last birthday) 89 YRS		
7a. BIRTHPLACE (State or foreign country) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? USA.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY Md.		
10. CITY OR TOWN OF DEATH OLNEY			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BROOK GROVE FOUNDATION Olney Md.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Funeral Soc.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN Kensington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 3000 FERNDALE ST			14. FATHER'S NAME First Middle Last Andrew Woodward			15. MOTHER'S MAIDEN NAME First Middle Last Jessie M. Lellan			16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		
16b. SOCIAL SECURITY NO 217-28-1850			17. INFORMANT MRS Philip YARNALL			Address Kensington, Md. 3000 Ferndale St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY CONGESTION 4339 DUE TO, OR AS A CONSEQUENCE OF CEREBRAL THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last ARTERIOSCLEROSIS (b) 1 YEAR (c) YEARS									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH TERM.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) GANGRENE OF FOOT - CACHEXIA - SEPSIS											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12/24, 1967 , to NOV. 7, 1968 , that (I) (we) last saw the deceased alive on NOV. 5, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Donald R. Lewis						22c. DATE SIGNED			22d. ADDRESS 700 CLOVERLY SIL. SPRING Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE Nov. 8, 1968			23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory			23d. LOCATION (City or Town) (County) (State) Prince George Maryland		
24. FUNERAL DIRECTOR Warner E. Pumphrey Inc. 8434 Ga. Ave. S.S., Md.						25a. REC'D BY REGISTRAR M. Andrew Duwall			25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

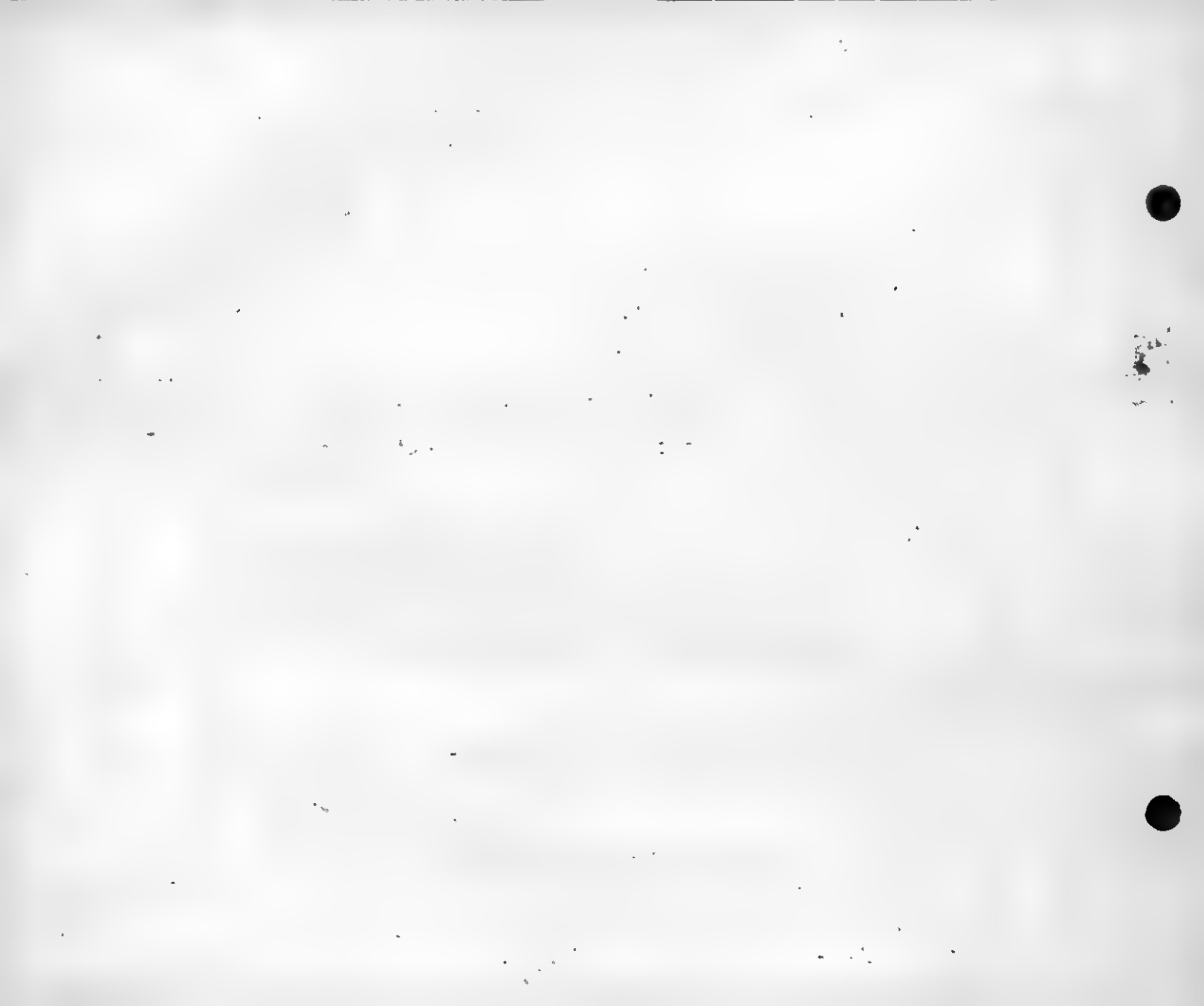
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16163

1617

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Alma Lee McCollum</i>			2a. DATE OF DEATH Month <i>11</i> Day <i>14</i> Year <i>68</i>			2b. HOUR <i>10:09 AM</i>				
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>4/10/03</i>		6 AGE (in years last birthday) <i>65</i> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (State or foreign country) <i>Georgia</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>				
10 CITY OR TOWN OF DEATH <i>Silver Spring, Md</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Cross Hospital</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Silver Spring</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>4311 Robert Court</i>		
14. FATHER'S NAME First <i>Linton</i> Middle <i>Stephen</i> Last <i>Lee</i>			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Jane</i> Last <i>Bizzard</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>218-52-5884</i>		17 INFORMANT <i>Mr. Harry J. McCollum</i>				Address <i>Sil. Spr. Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction due to Arteriosclerotic Heart Disease</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>7001</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 21, 1967</i> , to <i>Nov 10, 1968</i> , that (I) (we) last saw the deceased alive on <i>Nov 9, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>Nov 10, 1968</i>				
22d. PHYSICIAN'S NAME (Type) <i>BLAINE H. EIG</i>				22e. ADDRESS <i>9801 Derry Greenway, Md</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11-13-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>St. Myer Virginia</i>				
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>				ADDRESS <i>Sil. Spr. Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
8434 Georgia Avenue										



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16173	
16166											
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR			
First Middle Last MARY Emily McCREERY						Month Day Year Nov. 30 1968		12 noon			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		November 19, 1901		67 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Papphannock VA.		USA				MONTGOMERY				Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
OLNEY		Brooke Grove Foundation		BEAUTICIAN							
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER					
154 Franklin St. N.E. Wash. D.C.		Wash. D.C.		YES		154 Franklin St. N.E.					
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
John William Payne				Mary Thomas Hackley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (unknown) NO				16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
				212-01-7970A		Mrs. Mattie Peakes		154 Franklin St. N.E. Wash. D.C.			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary edema</u>										1-2 days	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u>										1-2 days	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Influenza acute</u>										2 wks	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>arteriosclerosis generalized. Chronic brain syndrome</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 10-16, 1968, to 11-30-1968, that (I) (we) last saw the deceased alive on 11-30-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John R. Spencer MD				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 11-30-68			
22d. PHYSICIAN'S NAME (Type) John R. Spencer				22e. ADDRESS BURTONSVILLE, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
burial		12/3/68		Arlington National Cem. Ft. Myer, Va.							
24. FUNERAL DIRECTOR		THE S.H. HINES CO		24b. ADDRESS 2901-14th St. N.W. WASH. D.C.		25a. REC'D BY REG. STRAR DATE DEC 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1

10165

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1617.3

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		Month		Day		Year		2b. HOUR	
ROSE						McCutcheon		Nov.		13		1968		12:00 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. COUNTY OF DEATH		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS		IF UNDER 24 HRS HOURS		M.N.	
FEMALE		WHITE		JAN 14, 1897		71 YRS.		Montgomery Co Md									
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		U.S.A.				Montgomery Co		Bethesda		SUBURBAN		Nurse		Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.	
MD		Montgomery		Wheaton				10820 Georgia Ave		Unknown		Unknown					
17. INFORMANT		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF Coronary atherosclerosis, ASHD, actual fibrillation (b) Generalized arteriosclerosis (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Hypertension		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr.		19a. DATE OF OPERATION 11/11/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Thrombosis Rpophtalaxia		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from April 1, 1968, to 11/17, 1968, that (I) (we) last saw the deceased alive on 11/12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Benne L Baudler MD		22c. DATE SIGNED 11/13/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE			
Dr. J. K. Huntman		5722 Georgia Ave N.E. Washington, D.C.		Burial		11/15/68		Cedar Hill Cemetery		Pr Geo Co Md		NOV 18 1968		Charles Judge			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form B-334-Reg-5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16166

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)		First JOSEPH	Middle F.	Last McLAUGHLIN	2a DATE KNOWN OF DEATH	<input checked="" type="checkbox"/> Month 11	Day 11	Year 1968	2b HOUR 10:40 PM
3 SEX Male	4 RACE White	5 DATE OF BIRTH May 28, 1893	6 AGE (in years) 75	7 UNDER 1 YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month 11 Day 11 Year 1968		2d HOUR 10:40 PM	
7a BIRTHPLACE (State or foreign country) Albany, N.Y.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md				
10. CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Chief - U. S. Navy		12b KIND OF BUSINESS OR INDUSTRY U. S. Navy			
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md.		13b. COUNTY Montgomery		13c CITY OR TOWN Sil. Spring	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 2101 Hildarose Drive			
14. FATHER'S NAME First Francis		Middle	Last McLaughlin	15. MOTHER'S MAIDEN NAME First Mary		Middle	Last Smith		
16a WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16b SOCIAL SECURITY NO. (If yes give year or dates of service) 1916-1919-1944		17. INFORMANT Amy McLaughlin		ADDRESS Sil. Sp., Md. 2101 Hildarose Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4a</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Underdetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Belden R. Keap, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED Nov. 12, 1968			
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE 11-15-1968		23c NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d LOCATION (City or Town) (County) (State) St. Myer, Virginia			
24 FUNERAL DIRECTOR C. Glen Carter		ADDRESS Warner E. Pumphrey, Inc. 8434 Georgia Avenue		25a REC'D BY REGISTRAR NOV 15 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										1618				
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH			2b. HOUR		
William J. McTighe									Month 11-20 Year 1968			2:15 PM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE		7 IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR	
Male		White		June 17, 1953		15 YRS		MONTHS DAYS MIN.		Month 11 Year 1968			12:15 PM	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED			9. COUNTY OF DEATH			Md.		
Texas			USA			NEVER MARRIED			Montgomery					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring				Holy Cross				Student				none		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland				Montgomery				Silver Spring		YES NO		14657 Stonewall Dr		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last		
E. James McTighe									Mary Dougherty					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS		
no				none				Silver Spring Maryland				E. James McTighe 14657 Stonewall Drive		
18. CAUSE OF DEATH (Enter only one cause per line or (a), (b) and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Disease (Picture)														
7462 DUE TO, OR AS A CONSEQUENCE OF (b) Congenital Heart Disease														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) (Tetralogy of Fallot)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES X NO		
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
				Hour A.M. P.M. 19										
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that I took charge of the remains described above, held an autopsy X inspection X inquiry X and in my opinion death resulted from: Natural causes X Accident Suicide Homicide Undetermined manner														
22b. DATE SIGNED				22c. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER										
Nov. 20, 1968				Belden R. Reap, M.D.										
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)				
Burial				Nov. 23, 1968		Gate of Heaven				Silver Spring, Maryland				
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
Warner E. Pumphrey, Inc. 8434 Ya. Avenue				DATE				NOV 25 1968						

16168

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16180

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with firm PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH Day Year			2b HOUR
Charles P. Mezger						11 9 1968			2:43 AM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 24 HRS MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR
Male	Cauc.	3/24/15	53 YRS			11 9 1968			M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			MD
Wash DC		USA				Montgomery			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY
Silver Spring			Holy Cross Hosp.			Power Plant Oper.			Elect Co
13a USLA. RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE			13b. COUNTY			13c STREET AND NUMBER			
Md.			Mont.			9806 Braddock Rd.			
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Charles P. Mezger			Clara Roxanna Triplett						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS			
Yes			Sept. 41-45 577 03 6195			Pauline Mezger 9806 Braddock Rd. Sil. Spr., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Artery Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Coronary Artery Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (City, town, or county)			22b DATE SIGNED			
Belden R. Reap M.D.			11/9/1968						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Burial			11-12-1968			George Washington Cemetery			Prince Georges, Maryland
24 FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Warner E. Pumphrey, Inc. 8434 Georgia Avenue			NOV 14 1968			Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
MILESTONE, DORA K.						11 Month 22 Day 68 Year		5:30 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS		
FEMALE		WHITE		MAY-5-1897		71 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
D.C.		U.S.A.				MONTGOMERY Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
SILVER SPRING			HOLY CROSS HOSPITAL			Nurse				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.			MONT.		SILVER SPRING		YES		1700 S.W. HIGHWAY	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
NATHAN KUPRAW			MINNIE STERMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO			5-18-16-066		MRS VIOLE OCKSMAN		9405 CROSS RD SILVER SPRING MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) INTACEREBRAL HEMORRHAGE									51 hours	
DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE AND/OR ARTERIO-SCLEROTIC VASCULAR DISEASE									YEARS	
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
11/20/68		TO MAINTAIN PATENT AIRWAY			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION		Street or R.F.D. No		City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from 11/20, 1968, to 11/22, 1968, that (I) (we) last saw the deceased alive on 11/22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED								
Edward S. Mehlman, M.D.		11/22/68								
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
EDWARD S. MEHLMAN, M.D.		6450 NEW HAMPSHIRE AVE TAKOMA PARK, MD								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		11-24-68		OHEW SHOLDON CEM.		WASHINGTON D.C.				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
GOLDEN FURNERAL HOME		4217 GAITHER RD		DATE NOV 26 1968		Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16170

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Jenny L. Miller</i>			2a. DATE OF DEATH 11 Month 6 Day 68 Year			2b. HOUR 7:30 P.M.		
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH 12-16-96		
6. AGE (In years last birthday) 77 YRS.			7. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>			8. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		
9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			10. COUNTY OF DEATH <i>Montgomery</i> Md.					
11. CITY OR TOWN OF DEATH <i>Bethesda</i>			12. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			13. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired Teacher</i>		
14. KIND OF BUSINESS OR INDUSTRY <i>Public Schools</i>			15. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			16. COUNTY <i>Mont.</i>		
17. CITY OR TOWN <i>Chevy Chase</i>			18. INSIDE CITY ERM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			19. STREET AND NUMBER <i>4610 Davidson Drive</i>		
20. FATHER'S NAME <i>Lemon Miller</i>			21. MOTHER'S MAIDEN NAME <i>Mary Magdalene Broughton</i>			22. SOCIAL SECURITY NO. <i>Not Avail.</i>		
23. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) <i>No</i>			24. INFORMANT <i>Mrs. Mary E. McGuire</i>			25. ADDRESS <i>Chevy Chase, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Myeloma</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 months.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>2 Congestive Heart Failure</i>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>10/15, 1968</i> , to <i>11/5, 1968</i> , that (I) (we) last saw the deceased alive on <i>11/5, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Richard H. Edenbaum MD</i>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>11/6/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>Richard H Edenbaum MD</i>			22e. ADDRESS <i>4700 Brndley Boulevard Ch. Ch. Md.</i>					
23a. MANNER OF DEATH <i>Burial</i>			23b. DATE <i>11-9-68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Husband Cemetery</i>		
23d. LOCATION (City or Town) (County) (State) <i>Somerset, Somerset Co. Pa</i>			24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>					
25a. REC'D BY REGISTRAR <i>NOV 13 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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VR A 54
30M REV 1/68

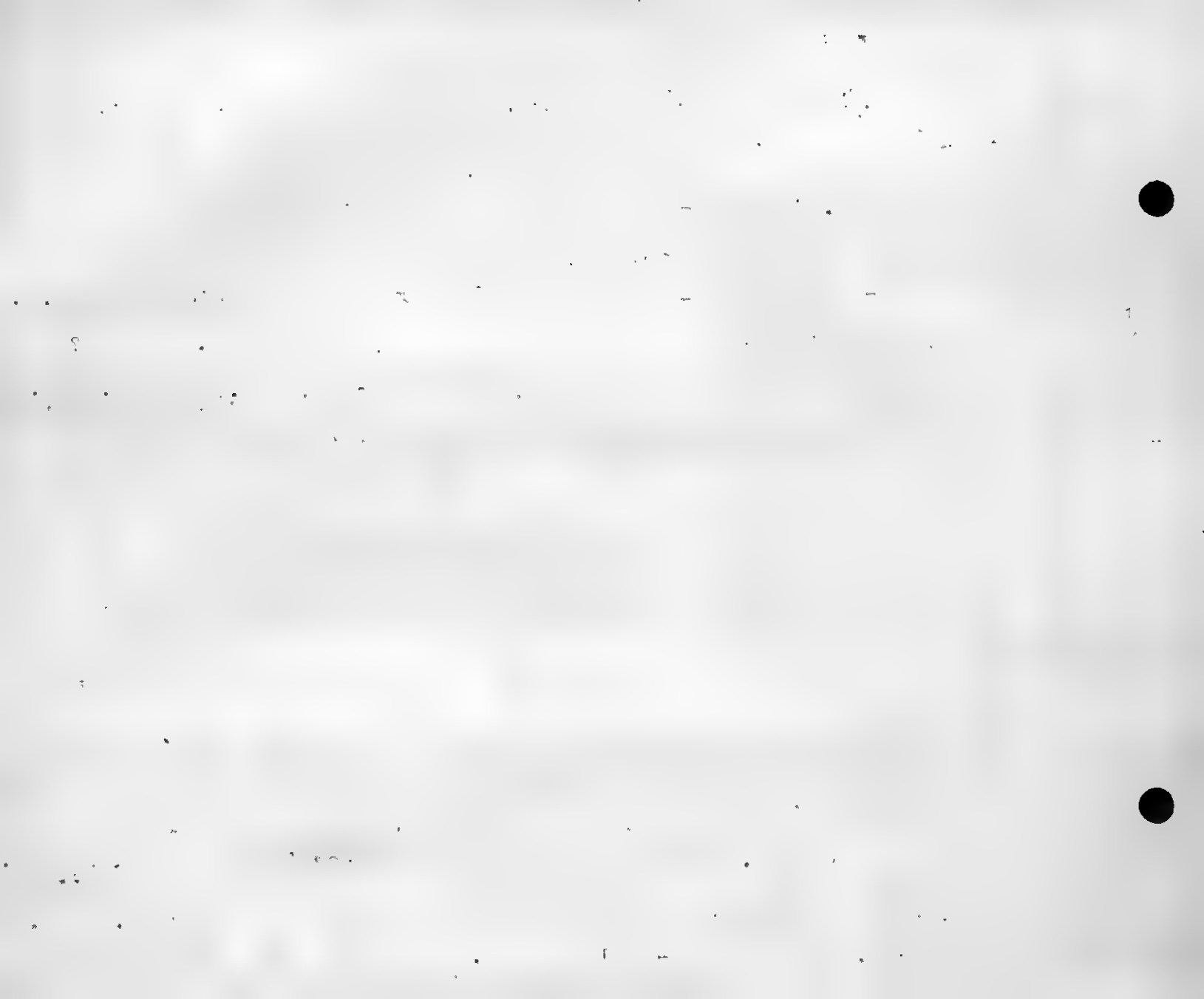
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16171

16185

1. DECEASED-NAME (Type or print) <i>Mary R Miller</i>			2a. DATE OF DEATH Month <i>11</i> Day <i>26</i> Year <i>68</i>			2b. HOUR <i>5:19</i> M			
3. SEX <i>F.</i>		4. RACE <i>CAUCASIAN</i>		5. DATE OF BIRTH <i>5/22/80</i>		6. AGE (In years last birthday) <i>88</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Campbell Co. Virginia-</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Wheaton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wheaton Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>-</i>		13b. COUNTY <i>-</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>613 Oneida Place N.W.</i>	
14. FATHER'S NAME First <i>James</i> Middle <i>Carol</i> Last <i>Marsh</i>			15. MOTHER'S MAIDEN NAME First <i>Mae</i> Middle <i>B.</i> Last <i>T</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <i>no</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <i>G. Gregg Everngam, Atty. 8700 Ga. Ave. Silver Spring, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ovarian carcinoma & metastases</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 mrs.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (1c) <i>1721</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>8-26</i> , 19 <i>68</i> , to <i>11-26</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/26</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <i>Myron L. Lenkin</i>		22c. PHYSICIAN'S NAME (Type) <i>Myron L. Lenkin</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED <i>11/26/68</i>	
22e. ADDRESS <i>8700 Georgia Avenue Silver Spg. Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11/30/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery Prince Georges Co. Md.</i>		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR ADDRESS <i>The S.H.Hines Company-2901 14th St. NW</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 29 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

MEDICAL CERTIFICATION



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print)			First Steven		Middle JOHN		Last MINNISH		2a DATE OF DEATH NOV. Month 24 Day 68 Year		2b HOUR 8:30 P.M.	
3 SEX Male			4 RACE Caucasian			5. DATE OF BIRTH Aug. 28, 1960			6 AGE (In years last birthday) 8 YRS		IF UNDER YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Maine			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery Md			
10 CITY OR TOWN OF DEATH Bethesda			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) N/A			12b. KIND OF BUSINESS OR INDUSTRY			
13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia			13b COUNTY Chesapeake			13c CITY OR TOWN Chesapeake			13d INSIDE CITY L.W. 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3014 Shelter Road	
14. FATHER'S NAME Richard L.			First Middle Last MINNISH		15. MOTHER'S MAIDEN NAME Ruth Florence Gaddas			First Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO N/A			17 INFORMANT Chesapeake Address Virginia Richard L. Minnish, 3014 Shelter Rd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute peritonitis</u> 7516 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Focal nodular hyperplasia of liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 7512												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from Oct. 18, 1968, to Nov. 24, 1968, that (X) (we) last saw the deceased alive on Nov. 24, 1968, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.												
22b SIGNATURE John R. Howe M.D.			DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED Nov. 26, 1968					
22d. PHYSICIAN'S NAME (Type) John R. HOWE, M. D.			22e. ADDRESS Naval Hospital, Bethesda, Md.									
23a BURIAL, CREMAT., REMOVAL (Specify) Burial			23b DATE 11-30-68		23c NAME OF CEMETERY OR CREMATORY Mount Zion Cemetery			23d LOCATION (City or Town) Dayton		(County) (State) Ohio		
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Md.						25a RECD BY REGISTRAR DEC 1 1968		25b REGISTRAR'S SIGNATURE Charles Jones				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16178

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16181

1 DECEASED NAME (Type or Print) STANLEY JOSEPH MOORE		First Middle Last		2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 11-26-68 <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year		2b HOUR 12:03 P.M.	
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH 10-19-26	6 AGE (in years) 42	7 IF UNDER YEAR MONTHS DAYS	8 IF UNDER 24 HRS MONTHS DAYS	2c DATE PRONOUNCED DEAD 11-26-68 <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 12:03 P.M.	
7a BIRTHPLACE (State or foreign country) Md.		7b CIT ZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY	
10 CITY OR TOWN OF DEATH Tacoma Park Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Hospital		12a USUAL OCCUPATION (Kind of work done during 24 hrs of week even if ended) PLANT WORKER		12b KIND OF BUSINESS OR INDUSTRY CP TET	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MD.		13b COUNTY Balto		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME John Moore		First Middle Last		15 MOTHER'S MAIDEN NAME Mary		First Middle Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b SOCIAL SECURITY NO 218-22-8366		17 INFORMANT SGT. CRAIGIE		ADDRESS Washington Hospital, Tacoma Pk Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound in head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) with exsanguination DUE TO, OR AS A CONSEQUENCE OF (c) self-inflicted							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 776 X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 11-26-68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 18 or Part 2 Item 18) Shot in left temple with pistol			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f. LOCATION Street or R.F.D. No Rte 97 City or Town Sunshine County Montgomery State Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Beelden R. Reaph		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED Nov. 26, 1968	
EXAMINER'S NAME (Type) BELOEN R. REAPH, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (City or town and county) Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/30/68		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or town) (County) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave. 21229				ADDRESS		25a. REC'D BY REGISTRAR NOV 29 1968	
						25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16176

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16176

1 DECEASED NAME (Type or Print) <i>Katherine E. Morales</i>			2a DATE KNOWN OF DEATH MATED <input type="checkbox"/> <i>Nov. 18</i> 19 <i>68</i> <i>87</i> M			2b HOUR <i>23</i>		
3 SEX <i>female</i>	4 RACE <i>white</i>	5 DATE OF BIRTH <i>11/22/07</i>	6 AGE (in years last birthday) <i>60</i> YRS	7 UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	8 IF UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>	2c DATE PRONOUNCED DEAD Month <i>Nov.</i> Day <i>18</i> Year <i>1968</i> <i>87</i> M		
7a BIRTHPLACE (State or foreign country) <i>T.C.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>		
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Public Relations</i>			12a USUAL OCCUPATION (Kind of work done during most of work no life even if retired)			12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>MD</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Bethesda</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>590-Nanna Kagan</i>
14. FATHER'S NAME First <i>Ralph</i> Middle <i>CLARK</i> Last <i>K</i>			15. MOTHER'S MAIDEN NAME First <i>Irene</i> Middle <i>Edsall</i> Last <i>Edsall</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16b SOCIAL SECURITY NO. <i>577-05-8270</i>		17. INFORMANT ADDRESS <i>Juliane Aubrey Morales, 590 Nanna Kagan</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive pulmonary infarction</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Mural thrombosis of right atrium</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John S. Beck</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <i>Nov. 19, 1968</i>		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
			ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b DATE <i>11-20-1968</i>		23c NAME OF CEMETERY OR CREMATORY <i>Lee's Crematory</i>		23d LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>		
24 FUNERAL DIRECTOR ADDRESS <i>Lee Fun. Home 300 4th St. NE Wash., D.C.</i>				25a RECD BY REGISTRAR DATE <i>NOV 22 1968</i>		25b REGISTRAR'S SIGNATURE <i>John S. Beck</i>		



20



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) <i>Dionides Hernandez Moreno</i>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <i>11</i> Day <i>30</i> Year <i>1968</i>		2b. HOUR <i>8⁴⁵ A.M.</i>			
3 SEX <i>MALE</i>		4 RACE <i>W.</i>		5 DATE OF BIRTH <i>MAY 8, 1927</i>		6 AGE (in years last birthday) <i>41</i> YRS.		7c. DATE PRONOUNCED DEAD Month <i>Nov.</i> Day <i>30</i> Year <i>1968</i>		2d. HOUR <i>8³⁵ A.M.</i>	
7a. BIRTHPLACE (State or foreign country) <i>CHILE</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>MONTGOMERY</i>					
10 CITY OR TOWN OF DEATH <i>Bethesda</i>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>SUBURBAN</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>U. S. Navy Dept</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <i>Md.</i>				13b. COUNTY <i>MONTGOMERY POTOMAC</i>		13c. CITY OR TOWN <i>POTOMAC</i>		13d. INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>11608 GOWRIE Ct.</i>	
14. FATHER'S NAME First <i>FAUSTINO</i> Middle <i>MORENO</i> Last <i>ARAYA</i>				15. MOTHER'S MAIDEN NAME First <i>DOMINGA</i> Middle <i>HERNANDEZ</i> Last <i>TORO</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16b. SOCIAL SECURITY NO <i>116-32-9967</i>		17 INFORMANT <i>Wife</i>		ADDRESS <i>Same as Item 13.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Occlusion</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arterio Sclerosis -</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hr.</i> <i>48 hr.</i> <i>years.</i>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4 - Chronic Glomerulo-Nephritis -</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John G. Ball</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>Nov. 30, 1968</i>			
EXAMINER'S NAME (Type) <i>John G. Ball</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, or county) <i>Bethesda, Maryland</i>							
23a. BURIAL PERMIT <input checked="" type="checkbox"/> CREMATION <input checked="" type="checkbox"/>				23b. DATE <i>12-3-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Maryland</i>			
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>						25a. REC'D BY REGISTRAR <i>DEC 9 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 407 MARYLAND STATE DEPARTMENT OF HEALTH
11-27-68ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #5, Film 3406 11/MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME (Type in Print) Georgeanne Simpson Morris		First Middle Last		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year 11-13 1968		2b. HOUR 7:45 A.M.	
3. SEX F	4. RACE W	5. DATE OF BIRTH April 5, 1923	6. AGE (in years last birthday) 45 YRS	7. UNDER 1 YEAR MONTHS _____ DAYS _____	8. UNDER 24 HRS HOURS _____ MIN _____	9. DATE PRONOUNCED DEAD 11 13	10. Year 1968
7a. BIRTHPLACE (State or foreign country) Tenn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash San & Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before) Maryland		13b. CITY OR TOWN Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME First George Middle S Last Simpson		15. MOTHER'S MAIDEN NAME First Pauline Middle Wilson Last Wilson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			
17. SOCIAL SECURITY NO 412-56-1757		18. INFORMANT 2326 Glenmont Circle Mr. John Morris Silver Spring, Md.					
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to 111X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration of gastric contents DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 11-13-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 11-13 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18.) Deceased, nauseated, vomited and aspirated gastric contents.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. no Silver Spring City or Town Montg. Md. County Montg. State Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE Belden R. Keap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED Nov. 13 1968	
EXAMINER'S NAME (Type) BELDEN R. KEAP M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, City, Town or County) Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-16-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery		23d. LOCATION (City or Town) Athens, Tenn. (County) (State)	
24. FUNERAL DIRECTOR J.W. Lee & Son Warner E. Pumphrey, Inc.		24a. ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REG. STAR NOV 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 4 to the funeral director. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16177										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										1019																																							
1 DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First MARY C. Middle Last MULLIKIN										Month Nov. Day 12 Year 1968										M																																							
3. SEX FEMALE										4. RACE CAUCASION										5. DATE OF BIRTH DEC. 4, 1878										6. AGE (in years last birthday) 89 YRS.										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) IRELAND										7b. CITIZEN OF WHAT COUNTRY? U. S. A.										B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH MONTGOMERY										Md																			
10. CITY OR TOWN OF DEATH SILVER SPRING										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) FAIRLAND NURS. HOME										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE										12b. KIND OF BUSINESS OR INDUSTRY																													
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND PRINCE GEORGES										13b. CITY OR TOWN BELTSVILLE										13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13d. STREET AND NUMBER 13210 GREEMONT AVE.																													
4. FATHER'S NAME First MICHAEL Middle Last BRODERICK										15. MOTHER'S MAIDEN NAME First JULIA Middle Last DOODY										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) NO (If yes give war or dates of service) NO										16b. SOCIAL SECURITY NO. 578-62-1048T										17. INFORMANT Wm. L. MULLIKIN JR. 12417 TAMPICO WAY										Address SIL. SP. MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis & right hemiplegia										8 mos																																																	
4129 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease										undeterm.																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)																																																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
4227																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (the hospital) attended the deceased from March 1956, to Nov 12, 1968, that (I) (we) last saw the deceased alive on Nov 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE William F. Simpson, MD										DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c. DATE SIGNED 11/12/68																																							
22d. PHYSICIAN'S NAME (Type) William F. Simpson, MD										22e. ADDRESS 6216 N.H. Ave NE - DC 20011																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE 11-14-68										23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY										23d. LOCATION (City or Town) SUITLAND (County) P.G. (State) MARYLAND																													
24. FUNERAL DIRECTOR FRANCIS J. COLLINS 500 UNIV. BLVD. WEST SILVER SPRING, MARYLAND										25a. REC'D BY REGISTRAR NOV 14 1968										25b. REGISTRAR'S SIGNATURE J. Charles Judge																																							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
16178																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First Ira			Middle Bradus			Last Mullis SR.			2a. DATE OF DEATH Month 3 Day 68 Year			2b. HOUR 3:15 AM		
3. SEX Male			4. RACE White			5. DATE OF BIRTH 8-29-77			6. AGE (In years last birthday) 91 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) N. Carolina			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery			Md.					
10. CITY OR TOWN OF DEATH Olney			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring			3d. INSIDE CITY LIMITS? NO <input type="checkbox"/>			13e. STREET AND NUMBER 14700 Claude Lane					
14. FATHER'S NAME First D.W. Mullis			Middle			Last			15. MOTHER'S MAIDEN NAME First Clementine			Middle Williams			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input checked="" type="checkbox"/>			16b. SOCIAL SECURITY NO (If yes give year or dates of service) 244 26 5010			17. INFORMANT Hospital Records			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																	
PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) SEPTICEMIA - GRAM NEGATIVE 2 DAYS																	
DUE TO, OR AS A CONSEQUENCE OF (b) PERINEPHRIC ABSCESS 1 WK -																	
DUE TO, OR AS A CONSEQUENCE OF (c) PYELONEPHRITIS, ACUTE 1 WK.																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES: ARTERIOSCLEROSIS: POST-MYOCARDIAL INFARCT-OLD																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (1) (this hospital) attended the deceased from OCT 1965 to NOV 3, 1968, that (1) (we) last saw the deceased alive on NOV 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Donald R. Lewis MD			22c. DATE SIGNED 3 NOV. 68			22d. PHYSICIAN'S NAME (Type) Dr. Donald Lewis			22e. ADDRESS 700 CLOVERLY SILVER SPRING MD								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 11-6-68			23c. NAME OF CEMETERY OR CREMATORY WINDGATE CEM			23d. LOCATION (City or Town) (County) (State) WINDGATE NC								
24. FUNERAL DIRECTOR W.N. CHAMBERS CO						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE Charles Judge								
1400 CHAPIN ST. N.W. WASH. D.C.						DATE NOV 14 1968											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1S179

RAYMOND

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

ANTHONY NEGUS

CERTIFICATE OF DEATH

1611

1. DECEASED-NAME (Type or print) First Middle Last <i>Raymond Anthony Negus</i>			2a. DATE OF DEATH Month Day Year <i>Nov. 7 1968</i>		2b. HOUR <i>11:45 AM</i>
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>10/2/11</i>		6. AGE (In years last birthday) <i>57</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Mass.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Lawyer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>	
13a. USUAL RESIDENCE (Where deceased lived, if in institution, residence before admission). STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Bethesda</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>8915 Grant St.</i>	
14. FATHER'S NAME First Middle Last <i>Philip Negus</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Sarah Davis</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>yes</i> (If yes give war or dates of service) <i>1959-1964</i>		16b. SOCIAL SECURITY NO. <i>020-05-4917</i>	17. INFORMANT <i>ANNA Negus - wife and same</i> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4109 Coronary occlusion</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>4201</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21a. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> not work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (the hospital) attended the deceased from <i>10/13</i> , 1968, to <i>11/2</i> , 1968, that (I) (we) last saw the deceased alive on <i>11/2</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Allen J. O'Neill M.D.</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>11/8/1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>Allen J. O'Neill</i>		22e. ADDRESS <i>8601 Old George Town Rd. Bethesda Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>11-12-1968</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Gettysburg National</i>		23d. LOCATION (City or Town) (County) (State) <i>Gettysburg, Penn.</i>	
24. FUNERAL DIRECTOR <i>Joseph G. Wier's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</i>		25a. REC'D BY REGISTRAR <i>NOV 12 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16180

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16180

1 DECEASED-NAME (Type or Print) First <u>Audrey</u> Middle <u>E.</u> Last <u>Newman.</u>			2a DATE KNOWN OF DEATH <input type="checkbox"/> EST <input checked="" type="checkbox"/> MATED <u>Nov 8 1968</u> 2b HOUR <u>7 A</u> M		
3 SEX <u>FE</u>	4 RACE <u>W.</u>	5 DATE OF BIRTH <u>8/19/1920</u>	6 AGE (In years last birthday) <u>48</u> YRS	IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>	F UNDER 24 HRS HOURS <u> </u> MIN. <u> </u>
7a BIRTHPLACE (State or foreign country) <u>ILL.</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 COUNTY OF DEATH <u>Montgomery</u> Md	
10 CITY OR TOWN OF DEATH <u>Rockville</u>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>13206 Twinbrook Pky</u>		12a USJAL OCCUPATION (Kind of work done during most of working life even if retired) <u>Clerk-Sears Roebuck & Co.</u>	
13a USUAL RES DENCE (Where deceased lived, if institution Res dence before admision) STATE <u>Md.</u>		13b COUNTY <u>Montgomery</u>	13c CITY OR TOWN <u>Rockville</u>	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <u>APT 202 13206 Twinbrook Pky</u>
14 FATHER'S NAME First <u>Adelbert Waite</u> Middle <u> </u> Last <u> </u>			15 MOTHER'S MAIDEN NAME First <u>Margaret Pribble</u> Middle <u> </u> Last <u> </u>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16b SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Daughter</u> <u>13200 Twinbrook Pky</u> <u>Kathleen Jan Wyvell- Rockville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage. Severe.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Rupture Berry Aneurysm Left Cerebral -</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u> </u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u> <u>Sudden.</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u> </u> P.M. <u>19</u>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <u>Nov. 9, 1968</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ADDRESS (Street, city, town, or county) <u>Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-13-68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 14 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-13M. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages read 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MAYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR	
REVER ELIZABETH NICKENS						Month Day Year			11 7 1968 9A M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 MONTHS	8 DAYS	9 HOURS	10 MIN	2c. DATE PRONOUNCED DEAD		2d. HOUR
Female	Negro	8/20/1900	68					Month Day Year		11 7 1968 9A M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Sandy Spring Md.		USA				Montgomery Md				
10. CITY OR TOWN OF DEATH			NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. LSUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring			Holy Cross Hospital			Domes.				
13a. USJA. RESIDENCE (Where deceased lived, if institution Residence before address) STATE			13c. CITY OR TOWN			13d. INSIDE CITY (Y/N)			13e. STREET AND NUMBER	
Washington D.C.						YES <input type="checkbox"/> NO <input type="checkbox"/>			3018 Sherman Ave. NW WashD.C.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
? ? Nicknes			Mary Carter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS				
						husband David 3018 Sherman Ave. NW WashD.C.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>lost.</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>Belden R. Peap</u> MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED				
EXAMINER'S NAME (Type) <u>BELDEN R. PEAP MD</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			<u>Nov. 7, 1968</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)	
BURIAL			11-12-68			ASH MEMORIAL CEM.			SANDY SPRING, MONTG, MD	
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REG. STRAR			25b. REGISTRAR'S SIGNATURE	
ROBERT L. SNOWDEN			ROCKVILLE., MD			DATE NOV 12 1968			<u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16188										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16188	
1 DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR	
First Middle Last NOCK										Month Day Year Nov. 18 68										1:57 PM	
3 SEX Male			4. RACE White			5 DATE OF BIRTH Nov 18 1968			6 AGE (In years last birthday) 0 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN 5						
7a. BIRTHPLACE (State or foreign country) Md.			7b. CITIZEN OF WHAT COUNTRY? America			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.												
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. COUNTY 103b			13c. CITY OR TOWN Prince G. Bowie			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 12202 Foxhill Lane												
14 FATHER'S NAME First Middle Last Maurice William Nock			15. MOTHER'S MAIDEN NAME First Middle Last Shirley Marie Burke			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no										16b. SOCIAL SECURITY NO.			17. INFORMANT Address Shirley Marie Burke		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) One maxillary 777X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 776X																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town			County State									
22a. I certify that (I) (this hospital) attended the deceased from Nov 18, 19 68 to Nov 18, 19 68 , that (I) (we) last saw the deceased alive on Nov 18 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																					
22b. SIGNATURE Donald Levitt M.D.			DEGREE M.D.			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 11/19/68												
22d. PHYSICIAN'S NAME (Type) 3233 Superior Ave			22e. ADDRESS Bowie Maryland																		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 11/19/68			23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven			23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland												
24. FUNERAL DIRECTOR Lyson Wheeler			ADDRESS 1331 Rockville Pike Rockville, Maryland			25a. REC'D BY REGISTRAR DEC 2 1968			25b. REGISTRAR'S SIGNATURE Charles Judge												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>16182</div> <div>CERTIFICATE OF DEATH</div>											
1. DECEASED-NAME (Type or print) George NMI MOSCHES						2a. DATE OF DEATH Month 11 Day 15 Year 68			2b. HOUR 12:55		
3. SEX male		4. RACE white/Cac.		5. DATE OF BIRTH 9/9/91		6. AGE (In years last birthday) 77 YRS.		7. IF UNDER 1 YEAR MONTHS		8. IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Lemberg, Austria		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery / Md					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Textile					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY Montg		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input type="checkbox"/>		13e. STREET AND NUMBER 3810 Jeffry St,			
14. FATHER'S NAME First Simon Middle NMI Last Noschkes				15. MOTHER'S MAIDEN NAME First Debra Middle NMI Last Wheaton, Md							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 082-09-9318		17. INFORMANT Address Daughter/Mrs. Debra Hochberg							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) 4201										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours 4 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Jan 1967 to Nov 15, 1968 , that (I) (we) last saw the deceased alive on Nov 15, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE B. Blaine H. E. H.		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/15/68							
22d. PHYSICIAN'S NAME (Type) BLAINE H. E. H.		22e. ADDRESS 9801 Deanna Ave Silver Spring									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Nov. 17, 1968		23c. NAME OF CEMETERY OR CREMATORY Beth Israel Cemetery		23d. LOCATION (City or Town) Woodbridge (County) New Jersey (State)					
24. FUNERAL DIRECTOR Donald M. Stein		ADDRESS 232 Carroll St., N.W. Wash.		25a. REC'D BY REGISTRAR NOV 19 1968		25b. REGISTRAR'S SIGNATURE William Yague					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16184

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16103

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Robert Emmett O'Brien			2a. DATE OF DEATH Nov 21, 1968 Month Day Year			2b. HOUR M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH 5/26/1900		6. AGE (In years last birthday) 68 YRS. 5 15		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md					
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Peoples Drug Store			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery Rockville			13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1100 Paul Drive	
14. FATHER'S NAME John J. O'Brien			15. MOTHER'S MAIDEN NAME Annie Purcell								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 578-13-0829			17. INFORMANT Elizabeth V. O'Brien wife's sister # 10					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Prostatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>177X Coronary artery disease</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-21-68</u> , to <u>11-21-68</u> , that (I) (we) last saw the deceased alive on <u>11-21-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>DL Bucy / SN Jones</u>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 11-21-68			
22d. PHYSICIAN'S NAME (Type) DL Bucy / SN Jones			22e. ADDRESS 809 Veirs Mill Rd Rockville Md								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 11/25/68			23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery			23d. LOCATION (City or Town) (County) (State) Silver Spring Mont. Md		
24. FUNERAL DIRECTOR Tyson Heeler Funeral Home 1771 Rock Pike Rockville, Maryland			ADDRESS			25a. REC'D BY REGISTRAR DATE NOV 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Coroner papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) MADELINE M. OFF						2a. DATE OF DEATH Month NOV. Day 18 Year 1968			2b. HOUR 3:20 A M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 3-23-1886		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS 8 DAYS 24		IF UNDER 24 HRS HOURS 32 MIN 0	
7a. BIRTHPLACE (State or foreign country) Phila., Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Kensington			11. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) 3000 McGraws Ave			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY own home		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Pa.			13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY, MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4000 Wexford Dr.		
14. FATHER'S NAME First F-Rank Middle M Last McKee			15. MOTHER'S MAIDEN NAME First Elizabeth Middle Kelly Last Md.								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO 220-46-5512			17. INFORMANT Address Marie Johnson 4000 Wexford Drive, Kensington Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Thrombosis - Rt. femoral art.											
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis											
DUE TO, OR AS A CONSEQUENCE OF (c) 10 days											
10 yrs.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED											
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)											
21b. TIME OF INJURY HOUR A.M. Month Day Year 19											
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)											
21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 7-15, 1965 , to 11-18, 1968 , that (I) (did) last saw the deceased alive on 11-9, 1968 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.											
22b. SIGNATURE D. J. Sengstack M.D.											
22c. DATE SIGNED 11-18-68											
22d. PHYSICIAN'S NAME (Type) George A. Sengstack, M.D.											
22e. ADDRESS 9241 Columbia Blvd., Sil. Spr., Md.											
23a. BURIAL (CREMATION, REMOVAL) (Specify) Burial											
23b. DATE 11-20-1968											
23c. NAME OF CEMETERY OR CREMATORY West Laurel Hill Cemetery											
23d. LOCATION (City or Town) (County) (State) Philadelphia, Penna.											
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Georgia Avenue											
25. REC'D BY REGISTRAR 1 1968											
25b. REGISTRAR'S SIGNATURE James J. Jones											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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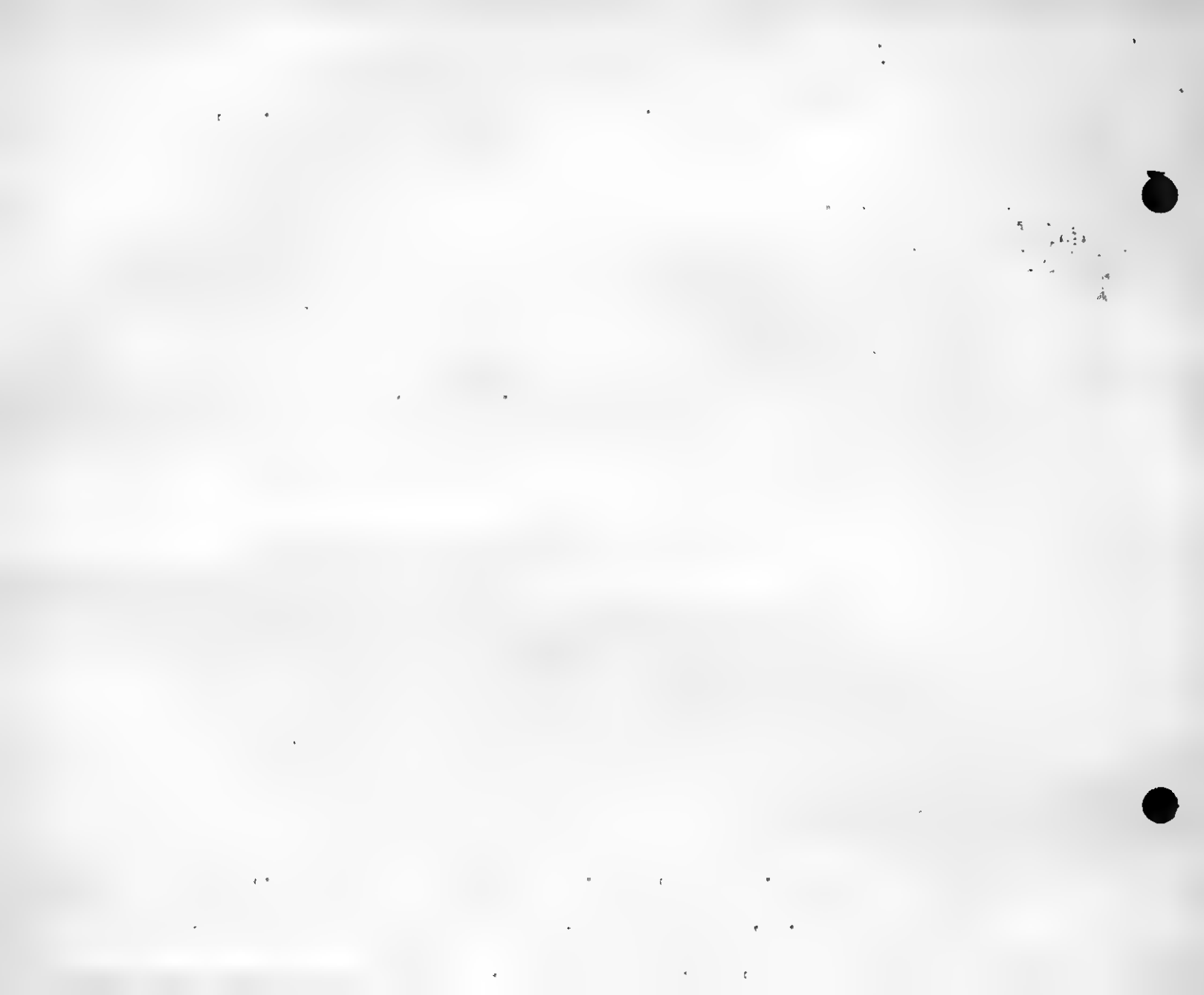
MONTGOMERY COUNTY DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
16186 CERTIFICATE OF DEATH 10260										
1. DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH	
ELSIE			L.		OFFUTT				Month 11 - Day 3 - Year 68	
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		NEGRO		August 6, 1887			81 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MD		U.S.A.				MONTGOMERY		Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
REDLAND MD			PLEASANT VIEW NURSING HOME			RETIRED			NONE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD			V HOWARD		CLARKSVILLE				RT# 2 BOX 121	
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME	
JAMES			MITCHELL		LYDIA		BROWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT			Address		
					MR ERNEST OFFUTT (SON)			RT#2 BOX 121		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident (Stroke)</u>										
DUE TO, OR AS A CONSEQUENCE OF: <u>Atherosclerotic Vascular Disease</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>331X</u>										
DUE TO, OR AS A CONSEQUENCE OF: (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Refusal to eat, Rheumatic Arthritis</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (the hospital) attended the deceased from <u>Aug. 15</u> , 19 <u>67</u> , to <u>Oct. 31</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct. 31</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Milton D. Westberg MD</u>						22c. DATE SIGNED <u>11-6-68</u>				
22d. PHYSICIAN'S NAME (Type) <u>Milton D. Westberg, M.D.</u>						22e. ADDRESS <u>431 N. Frederick Ave. Gaithersburg, Md. 20760</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
BURIAL		11-7-68		HOPKINS CHAPEL CEM.		HIGHLAND, HOWARD				MD
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
ROBERT L. SNOWDEN				ROCKVILLE, MARYLAND		DATE NOV 12 1968		<u>Charles Judge</u>		



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16187									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
ANNE			E. O'LAUGHLIN			Nov. 29, 1968			4:37 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS
Female		Caucasian		August 4, 1924			44 YRS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			10. MD
Washington, D.C.		USA				Montgomery			
11. CITY OR TOWN OF DEATH			12. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			13a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			14. KIND OF BUSINESS OR INDUSTRY
Bethesda			Suburban Hospital			Housewife			Home
15a. USUAL RESIDENCE (Where deceased admission) STATE			15b. CITY OR TOWN			15c. INSIDE CITY LIMITS?			15d. STREET AND NUMBER
Maryland			Chevy Chase			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			7504 Bybrook Lane
16. FATHER'S NAME			17. MOTHER'S MAIDEN NAME			18. CITY OR TOWN			19. STREET AND NUMBER
Curtis W. Handley			Helen			-			Emery
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			18. Address
no			579-34-1268			Mr. James P. O'Laughlin (husband)			#13 above.
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatorenal failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>3 weeks</u> <u>indeterminate</u> (b) <u>Laennec's cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>years</u> (c) <u>chronic alcoholism</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21c. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11-8-1968 to 11/29/1968, that (I) (we) lost saw the deceased alive on 11/29/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. DATE SIGNED			
Sidney J. Malawer		Sidney J. Malawer, M. D.		8218 Wisconsin Ave., Bethesda, Maryland		11/30/68			
23a. B. RIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Dec. 3, 1968		Gate of Heaven Cemetery		Silver Spring, Maryland			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons, Inc., Washington, D. C.				DEC 5 1968		Charles J. J. J.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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2

(Bj)

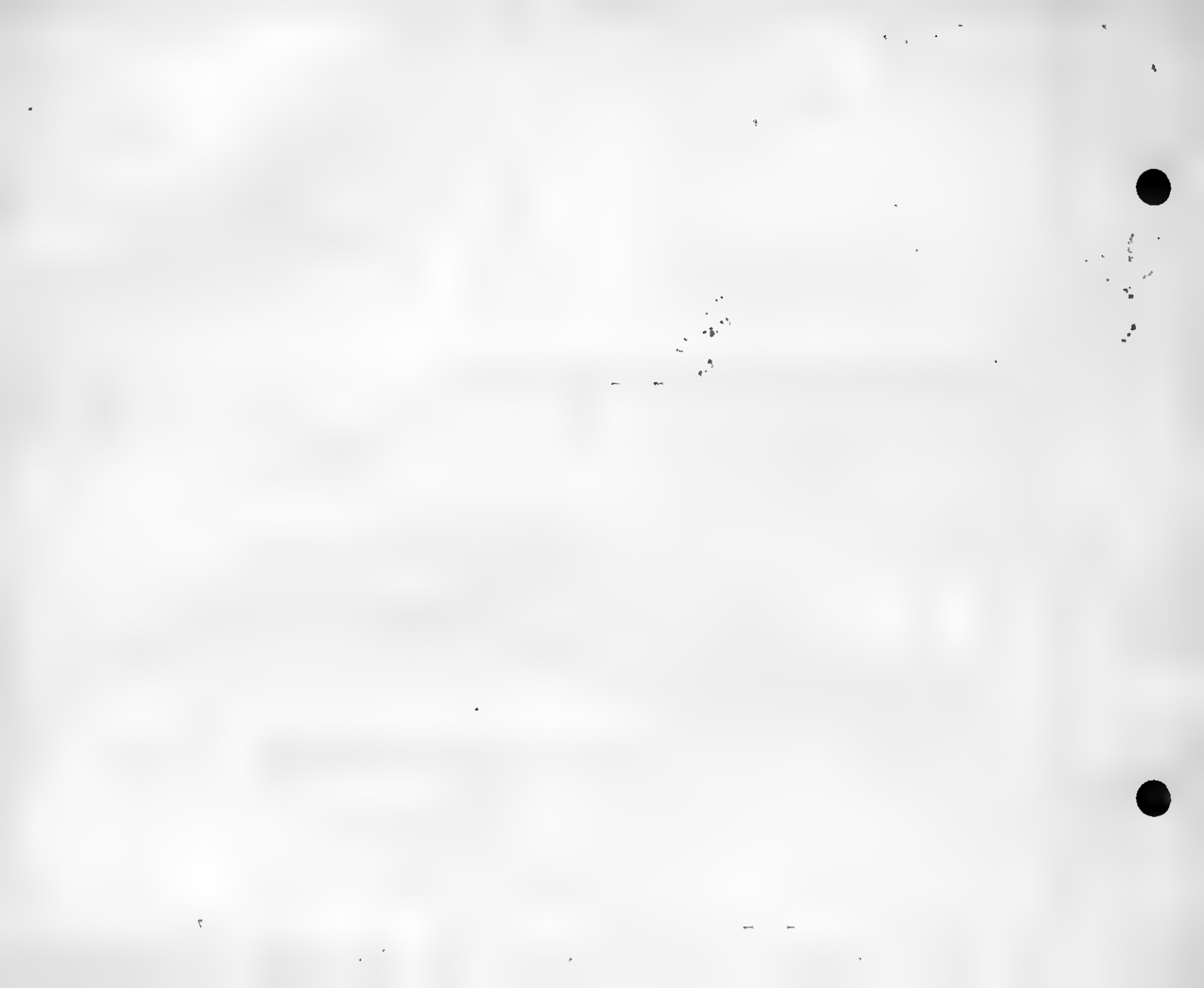
16188

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1620

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Raul</i> First <i>L</i> Middle <i>Oldfield</i> Last			2a. DATE OF DEATH Month <i>Nov</i> Day <i>7</i> Year <i>1968</i>			2b. HOUR <i>6:35</i> A.M.	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>10/1/1908</i>		6. AGE (In years last birthday) <i>60</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Fire Chief Ret</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Fire Dept</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>8712 Garfield St</i>							
14. FATHER'S NAME First <i>Fredrick</i> Middle <i>Oldfield</i> Last <i>Mabel</i>			15. MOTHER'S MAIDEN NAME First <i>F. Russell</i> Middle <i>Oldfield</i> Last <i>Oldfield</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>220-38-3321</i>		17. INFORMANT <i>wife Mary Oldfield</i>		Address <i>Same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Longstanding metastatic malignancy</i> <i>1541</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cancer of Lung</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cancer of Colon - Rectum</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> <i>1 yr.</i> <i>6 year</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>154X</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug</i> , 19 <i>63</i> , to <i>Nov 8</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Nov 9</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>James H. Scully</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>Nov 9 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>James H. Scully</i>				22e. ADDRESS <i>1835 Epps St NW Wash 20006</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11-11-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR DATE <i>NOV 13 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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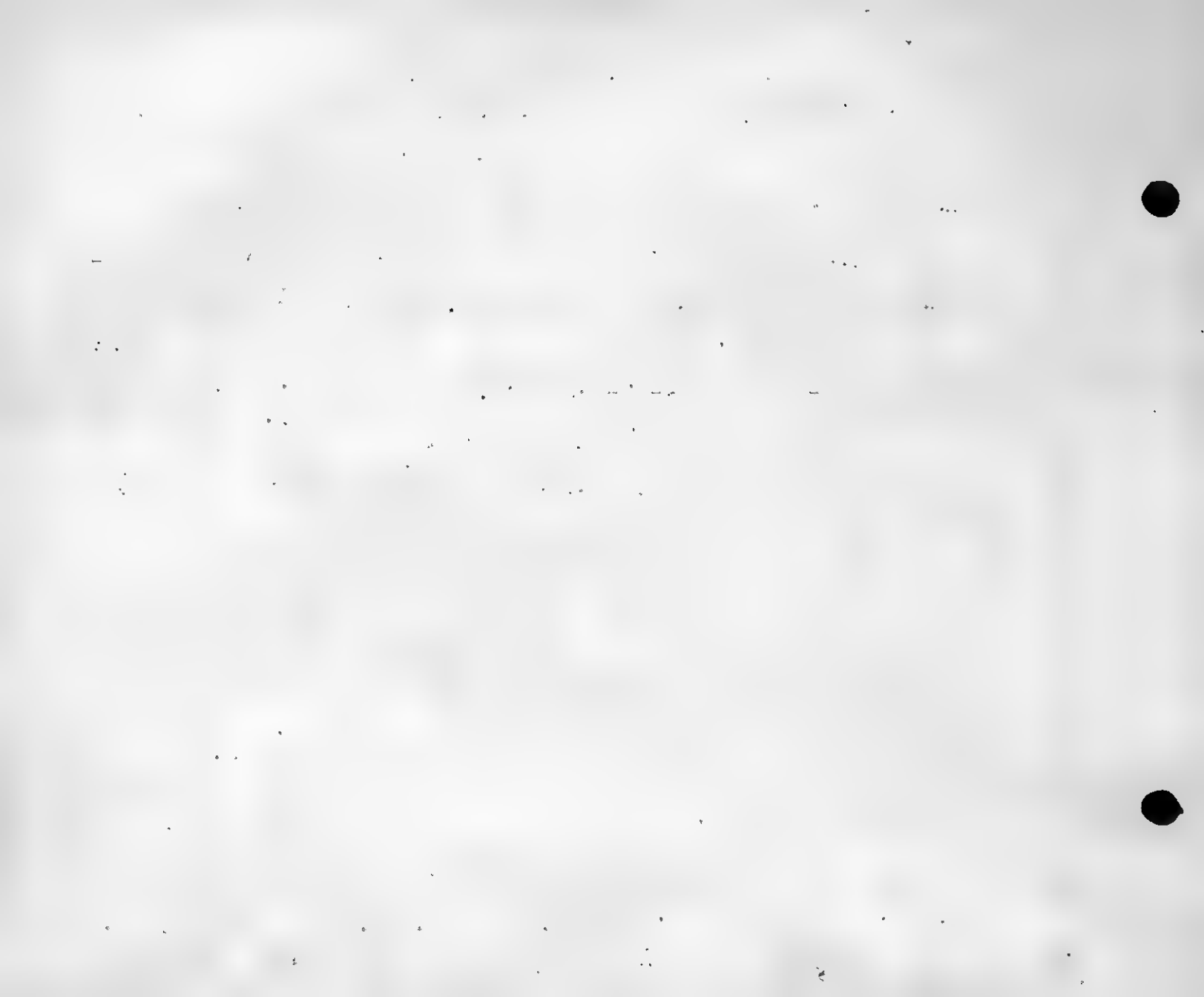
16189

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16203

CERTIFICATE OF DEATH

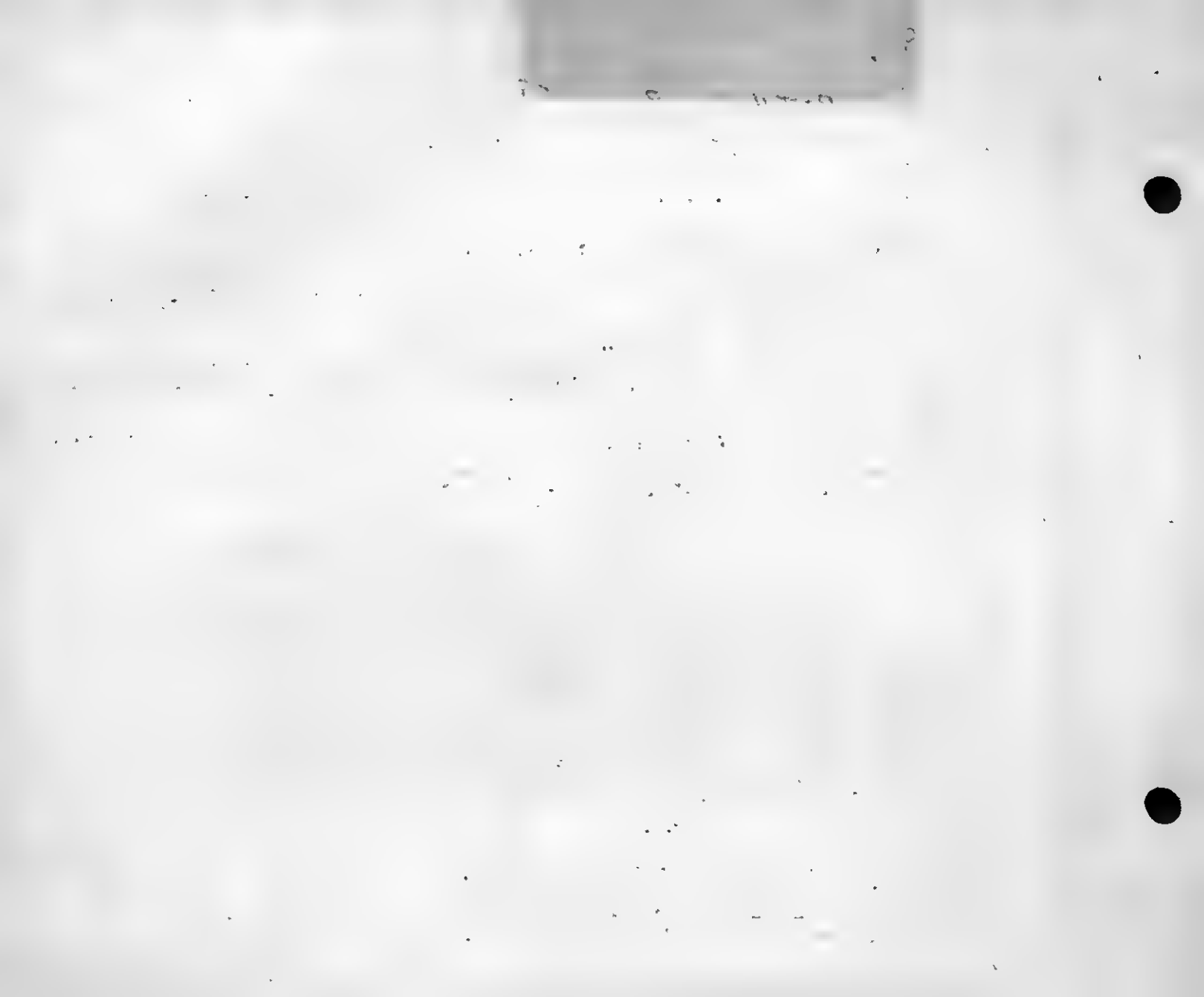
1. DECEASED NAME (Type or print) Timothy		First JAMES	Middle E.	Last O'NEILL	2a. DATE OF DEATH Month November Day 5 Year 1968		2b. HOUR M
3. SEX male	4. RACE white		5. DATE OF BIRTH 9/7/1924		6. AGE (In years last birthday) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Fairland Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Meat Packer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Sp.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 901 - Hollywood Ave	
14. FATHER'S NAME First Timothy Middle O'Neill Last			15. MOTHER'S MAIDEN NAME First ? Middle Sowers Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 214-03-1204		17. INFORMANT Mrs. Ethel L. O'Neill (above address)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 to 6 mos							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/8/68</u> , 19 <u>68</u> , to <u>11/5/68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/5/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Patricia J. Jameson</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/5/68	
22d. PHYSICIAN'S NAME (Type) Patricia J. Jameson				22e. ADDRESS 11718 Georgia Ave. Spring Hill			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11/8/68		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. Cem.		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR Valley's Funeral Home Inc.				ADDRESS t. Rainier Maryland		25a. REC'D BY REGISTRAR DATE NOV 12 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16190											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First RUTH		Middle B.		Last Pappano		2a. DATE OF DEATH Month 11 Day 27 Year 68		
3. SEX FEMALE		4. RACE white		5. DATE OF BIRTH 9/6/194			6. AGE (In years last birthday) 82 YRS.		2b. HOUR 6:10 PM		
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Bethesda					
10. CITY OR TOWN OF DEATH Md			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Grosvenor Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Mont		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 10661 Weymouth St.		
14. FATHER'S NAME First Frank Middle Boachio Last UNKNOWN			15. MOTHER'S MAIDEN NAME First UNKNOWN Middle UNKNOWN Last UNKNOWN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. 273-05-2808		17. INFORMANT C. L. Pappano		10661 Weymouth St. Bethesda, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular renal disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years 5 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 74											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 1960 , 19 68 , to 11/27 , 19 68 , that (I) (we) last saw the deceased alive on 11/26 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John E. Everett MD		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type) JOHN E. EVERETT MD		22e. ADDRESS 9400 Conn. Ave. Kensington Md					
23a. BURIAL, CREMATION, REINTERMENT (Specify)		23b. DATE 11-30-68		23c. NAME OF CEMETERY OR CREMATORY State of Heaven		23d. LOCATION (City or Town) (County) (State) S.S. Md. Fulton					
24. FUNERAL DIRECTOR Robert A. Pumphrey		24b. ADDRESS 7557 W. Hampson Ave.		25a. REC'D BY REGISTRAR DATE DEC 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10205

15191

1 DECEASED-NAME (Type or print) <i>Orion</i>		First <i>Orion</i> Middle <i>Edmond</i> Last <i>Patton</i>		2a. DATE OF DEATH Month <i>Nov.</i> Day <i>6</i> Year <i>1968</i>		2b. HOUR <i>8 PM</i>	
3 SEX <i>Male</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>9-25-09</i>		6 AGE (In years last birthday) <i>59 YRS</i>	
7a BIRTHPLACE (State or foreign country) <i>Penn.</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Physician</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Gov't</i>	
13a USUAL RESIDENCE (Where deceased lived, if not in hospital, give street address) STATE <i>Maryland</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Kearington</i>		13d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <i>3714 Astoria Road</i>		14 FATHER'S NAME First <i>John</i> Middle <i>Wellington</i> Last <i>Patton</i>		15 MOTHER'S MAIDEN NAME First <i>Frances</i> Middle <i>E</i> Last <i>Beamer</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) <i>No.</i>		16b SOCIAL SECURITY NO <i>YES</i>		17 INFORMANT <i>Centis H. Patton - brother</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs?</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))							
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis of Colon</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cholesterol</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Obesity</i>							
19a DATE OF OPERATION <i>10/29/68</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cancer of Colon</i>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED Where <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this-hospital) attended the deceased from <i>Oct</i> , 19 <i>68</i> to <i>Nov</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6 Nov</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>Ann M Dimitroff MD</i>				22c DATE SIGNED <i>Nov. 7, 1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>Ann M Dimitroff, MD</i>				22e. ADDRESS <i>11500 L. ...</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>11-9-1968</i>		23c NAME OF CEMETERY OR CREMATORY <i>Verona Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Oakmont, Alleghany, Pa.</i>	
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		ADDRESS <i>8434 Ga. Ave.</i>		25a RECEIVED BY REGISTRAR <i>NOV 12 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR AIS
45M

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16192											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) ANNA First				Middle G. Last PEARLMUTTER				2a. DATE OF DEATH Month Nov Day 18 Year 1968			
3 SEX FEMALE				4 RACE white				5 DATE OF BIRTH MAY 15, 1889			
7a BIRTHPLACE (State or foreign country) Russia				7b CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10 CITY OR TOWN OF DEATH Bethesda				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban				9 COUNTY OF DEATH Montgomery			
13a USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.				13b COUNTY Montgomery				13c CITY OR TOWN Rockville			
14. FATHER'S NAME First Oron Middle Glague Last Anna				15. MOTHER'S MAIDEN NAME First Anna Middle Anna Last Anna				12a USUAL OCCUPATION and of work done during most of working life, even if retired.)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 011 20 2 79				17 INFORMANT Harvey W. Pearlmutter Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized purulent peritonitis										4 days	
DUE TO, OR AS A CONSEQUENCE OF (b) Paralytic ileus and spontaneous perforation, bowel											
DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma, rectum (7 Days Post-operative)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11/15 , 1968, to 11/17 , 1968, that (I) (we) lost the deceased alive on 11/17 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE William H. Dickson				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c DATE SIGNED 11/18/68			
22d PHYSICIAN'S NAME (Type) WILLIAM H. DICKSON				22e ADDRESS 916 19TH ST N.W. WASH DC							
23a BURIAL, CREMATION, or TRANSIT Burial				23b DATE 11/21/68				23c NAME OF CEMETERY OR CREMATORY Beth Arabian			
23d LOCATION (City or Town) Brookline, Mass.				(County) (State)							
24 FUNERAL DIRECTOR Tyson Wheeler F. H.				ADDRESS 1331 Rockville Pike Rockville, Maryland				25a REC'D BY REG STRAR NPV 20 1968			
								25b REG STRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

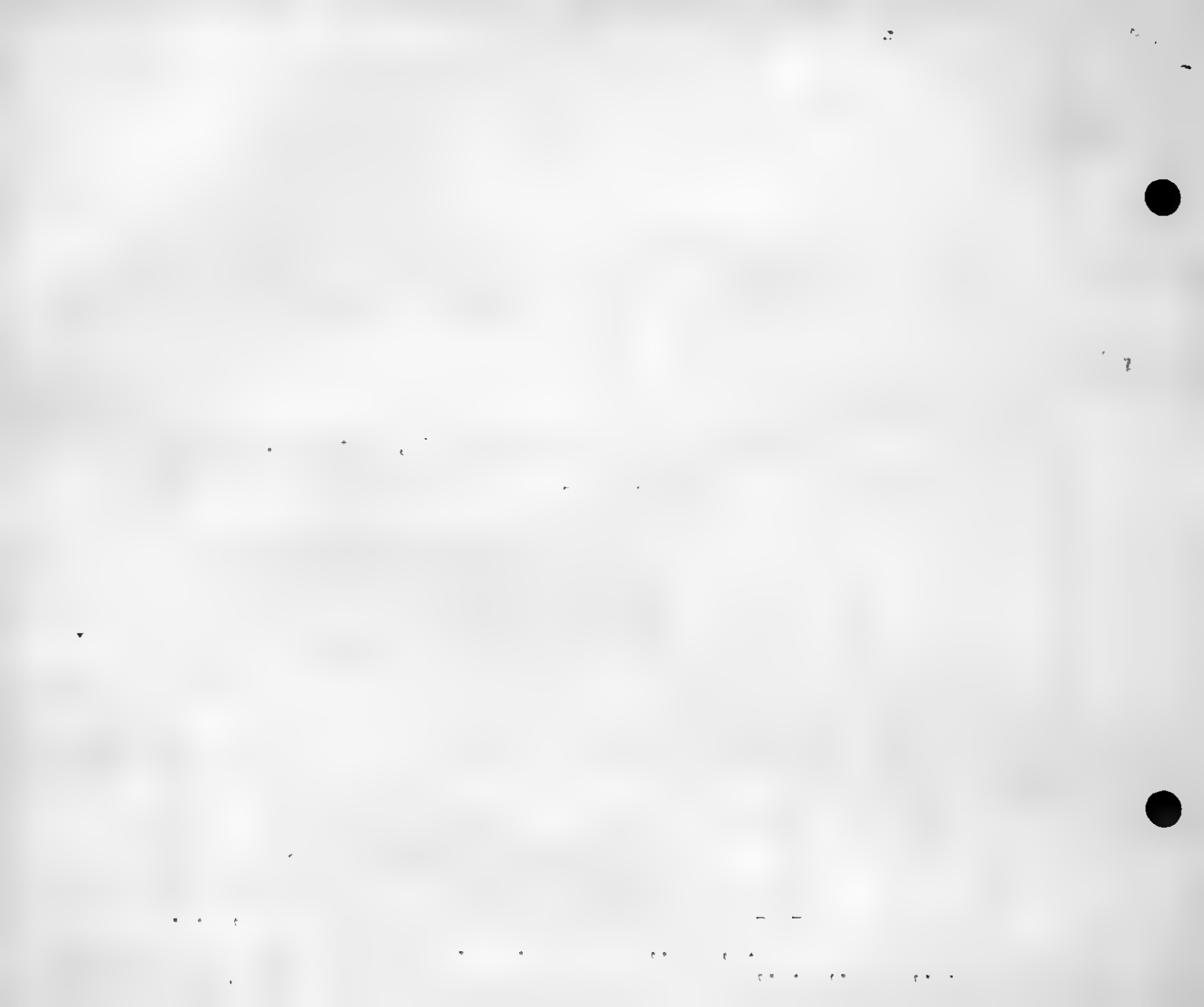
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FOR STATE
HEALTH DEPT.

Item # Film 407 12/5/68 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
18193 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16207

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
Stanton. Cantfield Peelle Jr.					MATED		11	24	1968	11:00
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)	IF UNDER 12 MONTHS	YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		2d HOUR
M.	W.	Nov-13-1906		62 YRS				Nov. Day 24 Year 1968		11:00
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Washington D.C.		U.S.A.				Montgomery		Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Bethesda.		Schorban.								
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Md.		Montgomery		Cherry Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6100 Conn Ave. ?		Cherry Chase
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Stanton		Grantford	Peelle		Julia				Ravenel.	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
Yes		578-03-7387		Sister		Cherry Chase, Md.		6 E. Melrose Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary thrombosis, left desc. branch		sudden								
4109										
DUE TO, OR AS A CONSEQUENCE OF (b) Advanced coronary arteriosclerosis		Years.								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
T. 101										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)						
		HOUR A.M. P.M. 19								
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		John E. Ball				M.D.		22b. DATE SIGNED		
EXAMINER'S NAME (Type)						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Nov/25, 1968		
						ADDRESS (Street, city, town, or county)				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		11-26-1968		Rock Creek Cemetery		Washington, D.C.				
24. FUNERAL DIRECTOR		ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Joseph Gawler's Sons, Inc., N.W., Wash., D.C., 20016		5130 Wisc. Ave.				DATE NOV 29 1968		Charles Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

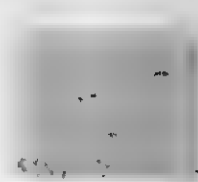
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10194

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10211

1. DECEASED NAME (Type or Print) BRIAN BECK PEYTON			First Middle Last			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Nov. 2 1968				2b. HOUR <input checked="" type="checkbox"/> 6 ^{AM}			
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH Aug 22 1968	6 AGE (in years last birthday) 2 YRS 2 11	7 UNDER YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year Nov 2 1968				2d. HOUR <input checked="" type="checkbox"/> 8 ^{PM}			
7a. BIRTHPLACE (State or foreign country) Wash. D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH MONTGOMERY				
10. CITY OR TOWN OF DEATH CABIN JOHN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4 Webb Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Infant			12b. KIND OF BUSINESS OR INDUSTRY Infant				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN CABIN JOHN			13d. INSIDE CITY LIM. IS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 4 WEBB ROAD	
14. FATHER'S NAME MARK PEYTON			First Middle Last			15. MOTHER'S MAIDEN NAME MYRTA FLOCK			First Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> unknown)			16b. SOCIAL SECURITY NO -----			17. INFORMANT MARK PEYTON - FATHER			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) (I.C.D.)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia - Interstitial Bilateral										24 hr.			
484X DUE TO, OR AS A CONSEQUENCE OF (b) VIROUS INFECTION										3 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5072													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HO. RA M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED Nov. 2, 1968					
EXAMINER'S NAME (Type) John G. Ball				7936 Old George Road Bethesda, Maryland				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL				23b. DATE 11/4/68				23c. NAME OF CEMETERY OR CREMATORY Mt. Zion					
23d. LOCATION (City or Town) (County) (State) Bethesda, Montg. Md.				23e. BY REG. STRAR 11/6/68				23f. REGISTRAR'S SIGNATURE J. Charles Judge					
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home Rockville, Md.													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MONTGOMERY STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
ROY			VEE	PEYTON	Month 11 Day -5- Year 68			M	
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE	NEGRO		3-7-1917			51 YRS.		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
N. CAROLINA			U.S.A.				MONTGOMERY Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
SENECA			VIOLETS LOCK RD			CUSTODIAN		NONE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MD			MONTG.		SENECA		YES		VIOLETS LOCK, RD
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
UNKNOWN						UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
NO									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
331X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>July 22, 1964</u> , to <u>Nov. 5, 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct 10, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>L. I. Leal</u> M.D. DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) LUCIANO I. LEAL					22e. ADDRESS MEDICAL CENTER, GAITHERSBURG, MD				
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		11-9-68		SENECA COMMUNITY CEM.		SENECA, MONTG. MD			
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>					ADDRESS ROCKVILLE, MARYLAND		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
ROBERT L. SNOWDEN					ROCKVILLE, MARYLAND		DATE NOV 12 1968		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in (including funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

clear 2 Dr. King

VS 8 15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16190

10200

1. DECEASED-NAME (Type or print) First Middle Last HAZEL, GRACE PIELSTICK			2a. DATE OF DEATH 11 Month 20 Day 1968		2b. HOUR 8:45 AM
3. SEX F male	4. RACE White	5. DATE OF BIRTH 6/29/91		6. AGE (In years lost-birthday) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Plaino, Ill	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hoy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Srg.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1912 Landsdowns Dr. SS Md.
14. FATHER'S NAME First Middle Last Robert ? Hawley		15. MOTHER'S MAIDEN NAME First Middle Last ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> none (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address husband Sidney 1912 Landsdowns Dr. SS Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4. <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Arteriosclerosis - Generalized</u> (c) <u>Emphysema</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201 <u>Emphysema</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>Dec</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 22, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>Nov. 23, 1968</u>	
22d. PHYSICIAN'S NAME (Type) <u>Arad S. Vosger, M.D.</u>		22e. ADDRESS <u>992 Counselman Rd. Pktnoc, Md</u>			
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) <u>Buried</u>		23b. DATE <u>Nov. 30, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	
23d. FUNERAL DIRECTOR <u>Arthur Walters, 257 Conrad St. Wash. DC</u>		23e. ADDRESS		23f. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 2 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH			<input checked="" type="checkbox"/> MATED	Month	Day	Year	2b HOUR
EARL ELTON PITTS						Nov 3 1968						8:30 P	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR	8 UNDER 24 HRS	2c DATE PRONOUNCED DEAD			Month	Day	Year	2d HOUR	
Male	white	10-30-19	49 YRS			11-3					68	8:30 P	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Virginia		Amer				Montgomery							
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during working life, even if retired)			2b KIND OF BUSINESS OR INDUSTRY				
Takoma Pk		Wash Sun & Hospital				Driver							
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Maryland		Pr Geo		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5801 15th Pl #202					
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last		
Richard Pitts						Edith Marders							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS				
yes			WWII			Hosp record							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute upper respiratory hemorrhage													
71.0 DUE TO, OR AS A CONSEQUENCE OF													
Conditions if any, which gave rise to immediate cause (a) secondary to fatty metamorphosis of													
stating the underlying cause liver.													
last DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
Chronic ethylism													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)							
			19 P.M.										
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town		County State		
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED				
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Nov. 4, 1968				
BOLDEN R. REAP M.D.						ADDRESS (Street, city, town, or county)							
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)					
Burial			11.6.68		Ft Lincoln Cemetery			Colmar Manor Maryland					
24 FUNERAL DIRECTOR						25a REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
300 4th St. N.E. Washington, D.C.						DATE NOV 6 1968			Charles Judge				

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in parentheses in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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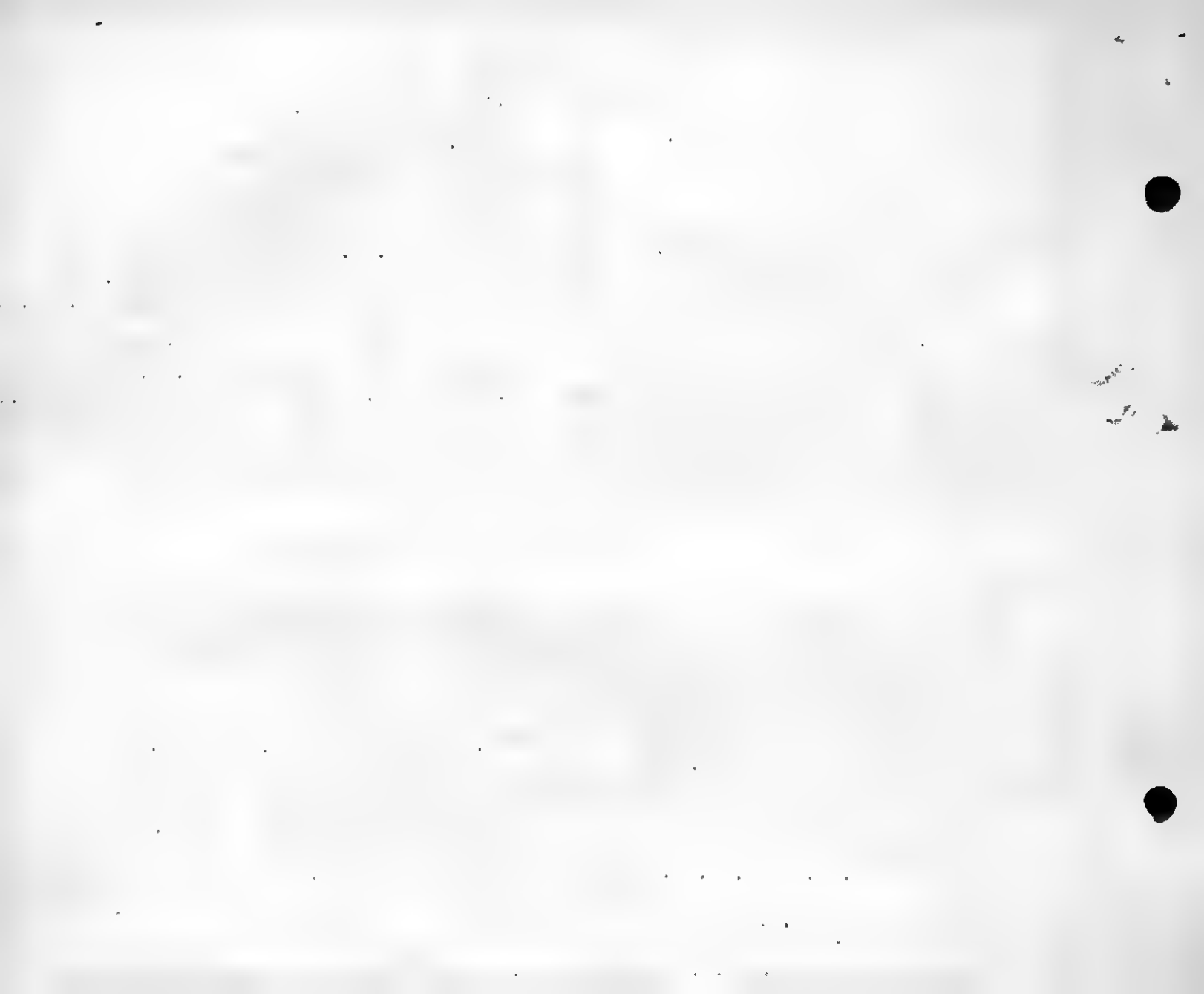
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
George C. Platt						Month Day Year 11-7 1968			4:30 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	7-28-51	17 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year 11-7 1968			4:30 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Austria		U.S.A.				Montgomery Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Suburban			Student			Public Schools		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Montgomery			Bethesda			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER					
Dolph W. Platt			Gertrude Ullmann			4516 Chase Avenue,					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT					
No			213-56-9599			(Father) Dolph W. Platt, Bethesda, Md.					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Perforating wound heart (gunshot)</u>											
755 X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
976											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
			4:30 PM Nov. 7 1968			Shot self in chest - 22 cal. R. F. 1/2.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town		
			Home			4516 Chase Ave. Bethesda.			Montgomery Md		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
John G. Ball			JOHN G. BALL, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			Nov 7, 1968		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) Montgomery Co. Md.		
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			11/11/68		Louden Park Natl. Cem.			Baltimore, Balt. Maryland			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
ROBERT A. PUMPHREY, Bethesda, Maryland						DATE NOV 14 1968		Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A
45M

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR
Joseph Philip PLICHTA									Nov. Month 26 Day Year 68			336 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Caucasian		Feb. 22, 1912			56 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md	
Minnesota			USA					Montgomery				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda			Naval Hospital			U. S. NAVY						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before address only) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
District of Columbia						Washington				Apt. 710 5432 Connecticut Ave., N.W.		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last
Joseph Plichta									Anna Cuchran			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>			16b. SOCIAL SECURITY NO			17. INFORMANT			18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Yes 1935-1958			031-30-2394			Mrs. Dorothy E. Plichta, 5432 Connecticut Ave.			Apt 1 710, Washington D. C.			
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Myocardial infarction												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
4109												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from Nov. 4, 1968, to Nov. 26, 1968, that (X) (we) last saw the deceased alive on Nov. 26, 1968 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED			
S. F. DOVI, M. D.									Nov. 29, 1968			
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS									
			Naval Hospital, Bethesda, Md.									
23a. BURIAL CREMATION			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Cremation			Dec. 2, 1968			Cedar Hill Crematory			Suitland, Maryland			
24. FUNERAL DIRECTOR			ADDRESS			25a. RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Joseph Gawler Sons			5130 Wisconsin Ave., N.W. Washington, D. C.			DEC 3 1968			Charles J. Jones			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print) <i>Francis Alvin Posey</i>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <i>Nov. 27 1968</i>			2b. HOUR <i>6:20 A.M.</i>			
3. SEX <i>MALE</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>1-3-09</i>	6. AGE (in years last birthday) <i>59</i> YRS	IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>	IF UNDER 24 HRS HOURS <i></i> MINS. <i></i>	2c. DATE PRONOUNCED DEAD Month <i>Nov.</i> Day <i>27</i> Year <i>1968</i>		2d. HOUR <i>6:20 A.M.</i>	
7a. BIRTHPLACE (State or foreign country) <i>MD. LAUREL</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Truck driver</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>MD.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>DAMASCUS</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>26917 Howard Chapel Drive</i>	
14. FATHER'S NAME First <i>William</i> Middle <i></i> Last <i>Posey</i>			15. MOTHER'S MAIDEN NAME First <i>Lillian</i> Middle <i></i> Last <i>Hill</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>216-10-1047</i>		17. INFORMANT <i>Charles Judge</i> ADDRESS <i>111 Hill</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction, recent, left myocardium and septum</i>								<i>Sudden</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Occlusion of left coronary artery</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary arteriosclerosis, marked</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John G. Ball</i>		7936 011 Georgetown, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>Nov 27, 1968</i>	
EXAMINER'S NAME (Type) <i>John G. Ball Bethesda, Maryland</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <i>111 Hill</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11/30/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Forest Oak</i>		23d. LOCATION (City or Town) <i>Gaithersburg, Md.</i> (County) <i></i> (State) <i>MD.</i>			
24. FUNERAL DIRECTOR <i>Tyson Wheeler 1331 Rockville Pike, Rock. Md.</i>				ADDRESS <i></i>		25a. REC'D BY REG STRAR <i>DEC 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

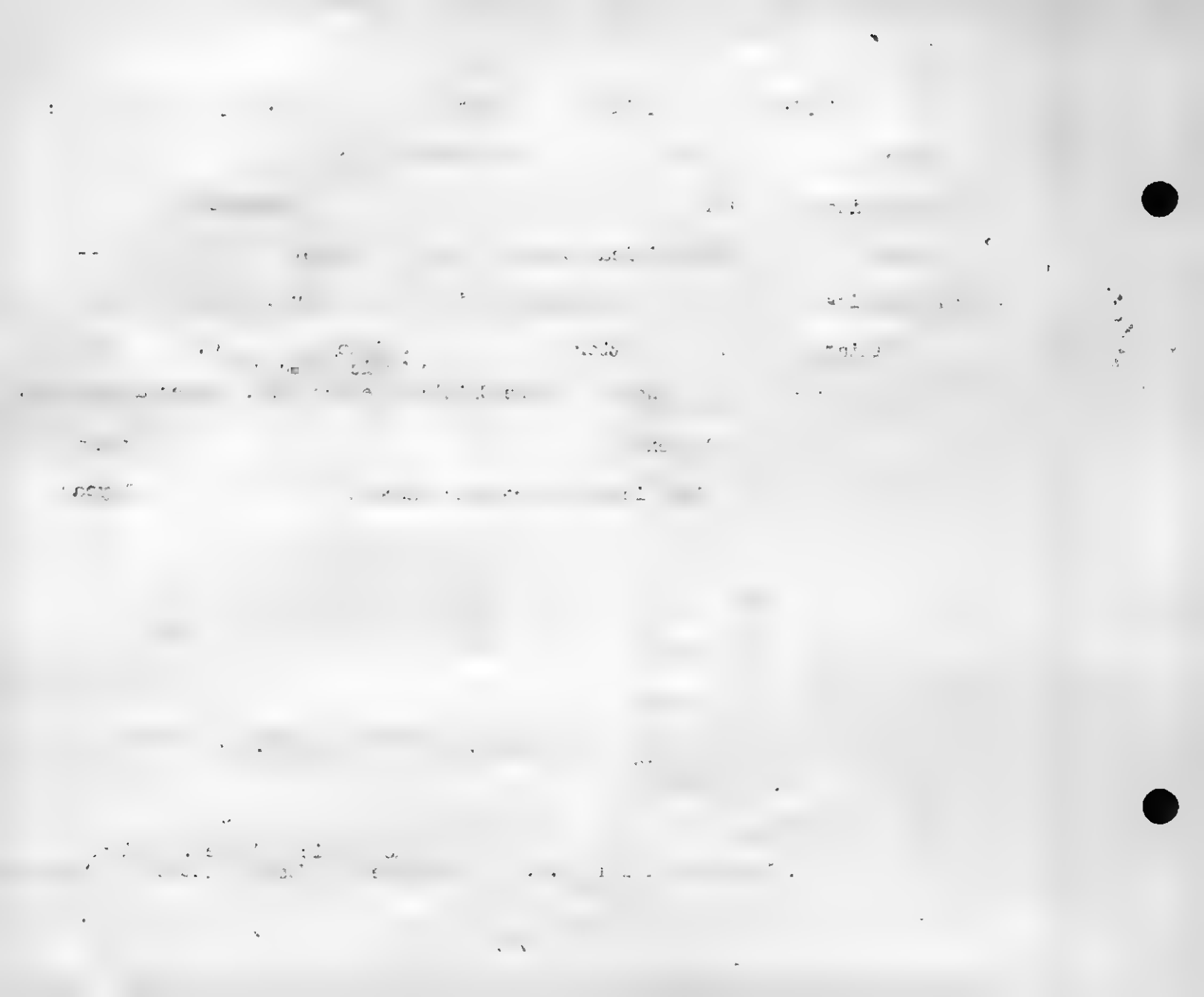
16201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year			2b. HOUR P M	
William David Potter						November 22 1968			5:10 P	
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER YEAR		8 UNDER 24 HRS.
Male		White		23 January 1956		12 YRS.		MONTHS DAYS		HOURS MIN.
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
North Carolina		USA				Montgomery Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Bethesda			The Clinical Center, NIH			Student			--	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE			13b. COUNTY			13c CITY OR TOWN		13d INSIDE CITY: HMTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
North Carolina						Willow Springs		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Route 1, Box 76
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
William H. Potter			Shirley G. Denton							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.			17 INFORMANT				
No			None			The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland				
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:										weeks
IMMEDIATE CAUSE (a) <u>Cachexia</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Disseminated osteogenic sarcoma</u>										1 year
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a ACCIDENT WAS UNDERLYING		21b TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19								
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (X) (this hospital) attended the deceased from <u>Sept. 22, 1968</u> , to <u>Nov. 22, 1968</u> , that (X) (we) last saw the deceased alive on <u>22 November 1968</u> , and that in <u>1968</u> (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death										
22b. SIGNATURE		22c. DATE SIGNED								
<u>H. Bryan Neel</u>		<u>11/22/68</u>								
22d PHYSICIAN'S NAME (Type)		22e ADDRESS								
H. Bryan Neel, III, M.D.		The Clinical Center, National Institutes of Health, Bethesda, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<u>BURIAL</u>		<u>11-26-68</u>		<u>Willow Springs Baptist Cem</u>		<u>Willow Springs WAKE NC</u>				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
<u>W.W. CHAMBERS CO.</u>		<u>400 CHAPIN ST.</u>		<u>11-23-68</u>		<u>Charles Judge</u>				
<u>N. W. WASH. D. C.</u>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 10 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16202										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16216									
1 DECEASED NAME (Type or print)										2a DATE OF DEATH										2b HOUR									
Annie LEE Pratt										Nov 28-1968										5:15 A.M.									
3 SEX										4. RACE										5. DATE OF BIRTH									
Female										white										March 21-1888									
7a BIRTHPLACE (State or foreign country)										7b CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>									
Virginia										U.S.A.										9. COUNTY OF DEATH									
10 CITY OR TOWN OF DEATH										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)									
Rockville										Potomac Valley N. Hosp										none									
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b COUNTY										13c CITY OR TOWN									
MD										MENT										Bethesda									
14 FATHER'S NAME										15 MOTHER'S MAIDEN NAME										16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)									
Leonidas A. Harris										Alethia Barthleson										No									
16b SOCIAL SECURITY NO										17 INFORMANT										18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))									
218-05-6328										Son										PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma</u>									
										William L. Pratt										Address Same as Item 13.									
																				PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
																				19a DATE OF OPERATION									
																				19b CONDITION FOR WHICH OPERATION WAS PERFORMED									
																				20a AUTOPSY?									
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
																				20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
																				21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									
																				21b TIME OF INJURY									
																				HOUR A.M. Month Day Year									
																				P.M. 19									
																				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)									
																				21d INJURY OCCURRED									
																				While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
																				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)									
																				21f LOCATION Street or R.F.D. No. City or Town County State									
																				22a I certify that (I) (this hospital) attended the deceased from 10/28, 1968, to 11/18, 1968, that (I) (we) last saw the deceased alive on 11/18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
																				22b SIGNATURE									
																				DEGREE									
																				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>									
																				22c DATE SIGNED									
																				11-28-68									
																				22d PHYSICIAN'S NAME (Type)									
																				WILLIAM T. JOYCE									
																				22e ADDRESS									
																				4977 Battery Lane									
																				Bethesda, Maryland									
																				23a BURIAL, CREMATION, REMOVAL (Specify)									
																				23b DATE									
																				11-29-68									
																				23c NAME OF CEMETERY OR CREMATORY									
																				Cedar Hill Crematory									
																				23d LOCATION (City or Town) (County) (State)									
																				Suitland, Maryland									
																				24 FUNERAL DIRECTOR									
																				ADDRESS									
																				ROBERT A. PUMPHREY, Bethesda, Maryland									
																				25a RECEIVED BY REGISTRAR									
																				DEC 4 1968									
																				25b REGISTRAR'S SIGNATURE									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in the funeral director's office. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-6-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
NORA			E PRATT			Nov 6 1968		9 ³⁰ A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR	
Female		White		12-8-1901		66 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
PENNA.		U.S.A.				MONTGOMERY		Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Kensington			Kensington Gardens SANIT			Purchasing Agent		Natl Radio	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.			MONTGOMERY			SILVER SPRING		10403 Royal Road.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Eugene Pratt Maud Moyer									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT (Name and Address)			
No			577-03 6185A			M. Louis C. Hurst 10403 Royal Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4401 Cardiac Arrest									10 minutes
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Atherosclerosis									10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
Esophageal obstruction (intermittent) 1 yr.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED: White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 1-9-60, 1960, to 11-6, 1968, that (I) (we) last saw the deceased alive on 11-6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
James T. Burns		11-6-68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
JAMES T. BURNS		1825 EYE BL., D.W.							
23a. BURIAL, CREMATION, REMOVAL, OR OTHER		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		11-9-1968		Congressional Cem		19th St Wash, D.C.			
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. REGISTRAR'S SIGNATURE		24c. DATE			
W.W. Chambers Co		Silver Spring Md		Charles Judge		NOV 8 1968			

MEDICAL CERTIFICATE

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

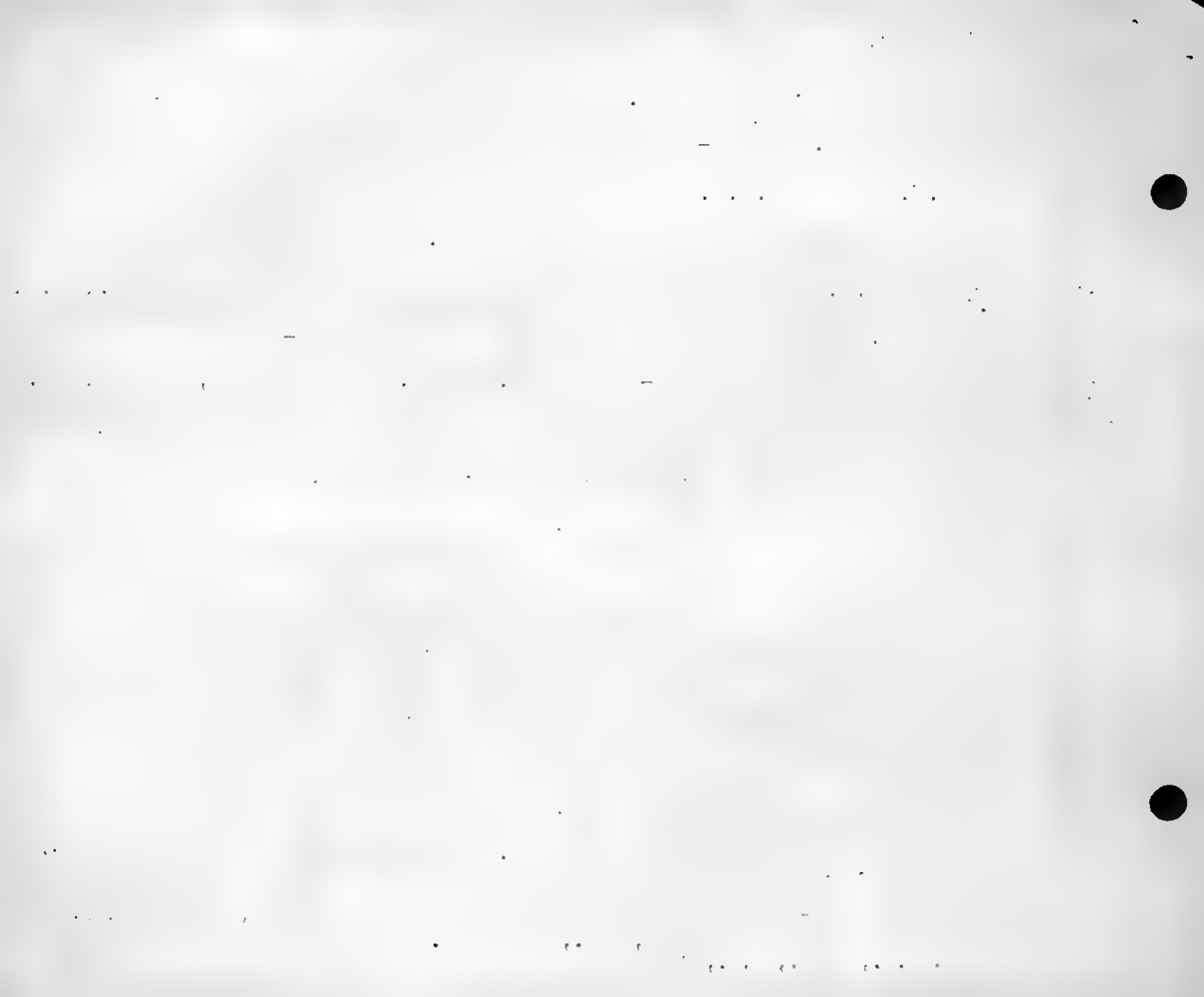
16204

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16213

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Marguerite M. Presley			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 11 Day 26 Year 1968			2b HOUR 12 a.m.		
3 SEX Female	4 RACE Cauc.	5 DATE OF BIRTH 6-30-1895	6 AGE (in years last birthday) 73 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c DATE PRONOUNCED DEAD Month 11 Day 26 Year 1968		
7a BIRTHPLACE (State or foreign country) N.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY at home	
13a USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.			13b COUNTY Washington		13c CITY OR TOWN Washington		13d YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME John J. Manning			15 MOTHER'S MAIDEN NAME -			13e STREET AND NUMBER 3217 Morrison St., N.W.		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b SOCIAL SECURITY NO -			17. INFORMANT Dr. Jon M. Presley, son, Sumner, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure DUE TO, OR AS A CONSEQUENCE OF Cerebral-vascular Thrombosis DUE TO, OR AS A CONSEQUENCE OF Generalized Arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Fractured Left hip with surgical reduction								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOJRA M. 10-27-68 P.M.			21c HOW INJURY OCCURRED (Explain nature of injury in Part 1 or Part 2) Patient fell over railing to bathroom at home		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home			21f LOCATION Street or RFD No 3217 Morrison City or Town Wash. D.C. County Dist. of State D.C.		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE Belden R. Reap			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED Nov. 26, 1968		
EXAMINER'S NAME (Type) BEIDEN R. REAP M.D.			ASS STANT MED. CA. EXAM. NER <input type="checkbox"/>			DEPUTY MED. CA. EXAM. NER <input checked="" type="checkbox"/>		
23a BURIAL CREMATION, REMOVAL (Specify) Removal			23b DATE 11-29-1968			23c NAME OF CEMETERY OR CREMATORY Charlotte, North Carolina		
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.,			25a REC'D BY REGISTRAR DEC 2 1968			25b REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

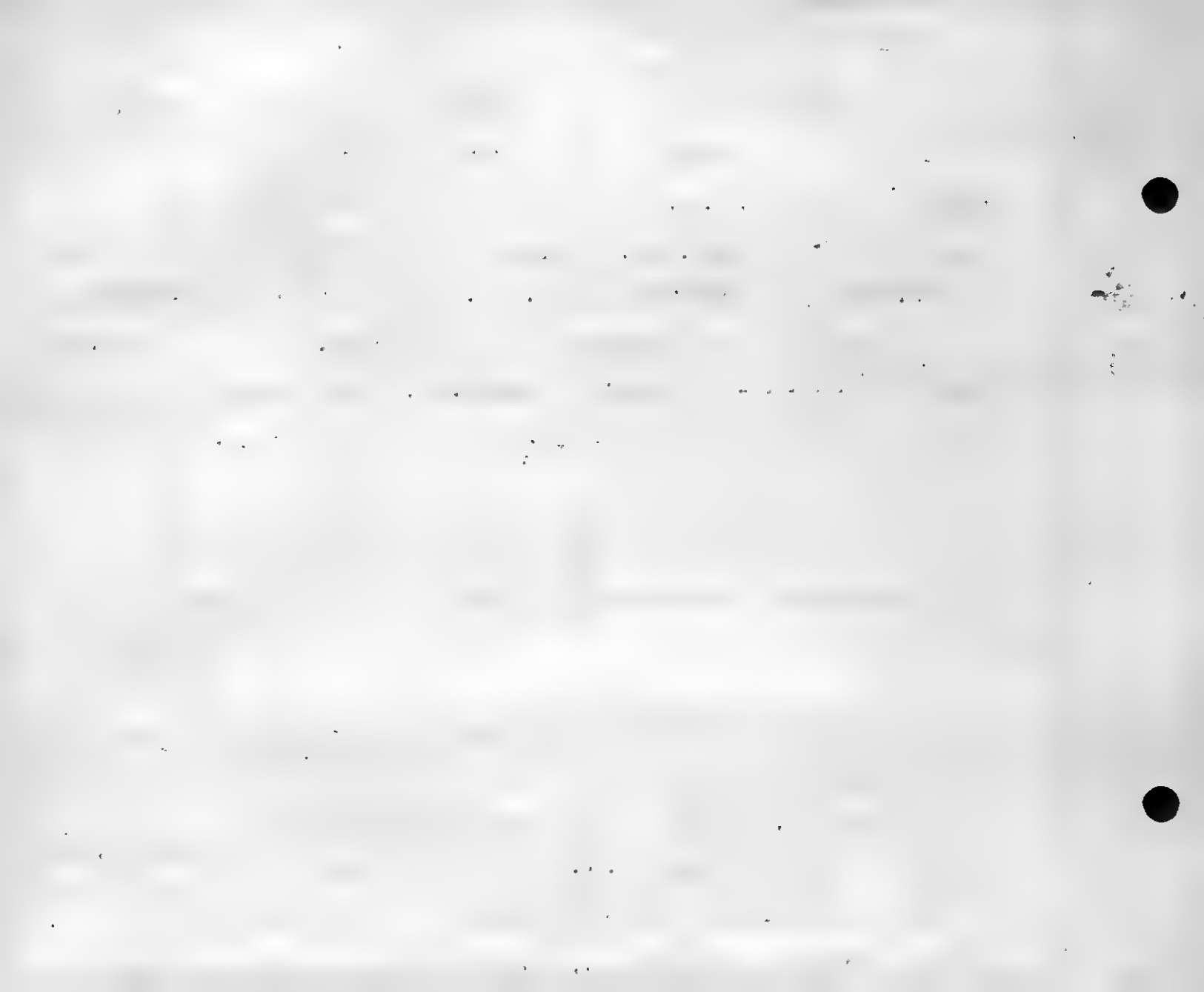
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16205

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16210

1. DECEASED-NAME (Type or print) ELIZABETH			First Middle Last			2a. DATE OF DEATH Month NOVEMBER Day 19 Year 1968			2b. HOUR 6:00 AM		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH APRIL 24, 1894			6. AGE (In years last birthday) 74 YRS.		
7a. BIRTHPLACE (State or foreign country) HUNGARY			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY Md.		
10. CITY OR TOWN OF DEATH TAKOMA PARK			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASH. SAN. & HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY -----		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN SIL. SPR.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 11215 OAKLEAF DRIVE			14. FATHER'S NAME First SOMA Middle EHRENFELD Last BARBARA			15. MOTHER'S MAIDEN NAME First BARBARA Middle EHRENFELD Last EHRENFELD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO. NONE			17. INFORMANT LEO PRICE, SAME AS 13			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 428X DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4-4-4</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 24, 1968</u> , to <u>Nov 19, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov 18, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Boris Rabkin</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>Nov 19, 1968</u>		
22d. PHYSICIAN'S NAME (Type) BORIS RABKIN, M. D.						22e. ADDRESS 1019 University Boulevard, East Silver Spring, Maryland					
23a. BURIAL, CREMATION, REMOVA (Specify) Burial			23b. DATE 11-20-1958			23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery			23d. LOCATION (City or Town) (County) (State) Rochelle Park N. J.		
24. FUNERAL DIRECTOR Goldberg Funeral Home 4217 9th St., N.W.						25a. REC'D BY REGISTRAR DATE NOV 21 1968			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16206											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Ina Josephine Pritchard						Nov Month 16 Day 1968			4:00 A.M.		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR			
Female		Caus.		12/31/1899		68 YRS.		MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Greenville, Tenn.		USA				Montgomery Md.					
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Cheaton		University Nursing Home		Office Clerk							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM 157		13e. STREET AND NUMBER		
D.C.					Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2311 33rd Street, S.E.		
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
George					Click	Ellen					Jaynes
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT						
			77-10-1954		Albert L. Pritchard. 2311. 33rd st S E						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>4409</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>cerebral atrophy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis</u>									<u>hours</u> <u>minutes</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4250</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>9-12-1968</u> to <u>11-14-1968</u> , that (I) (we) last saw the deceased alive on <u>11-16-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>David A. Horowitz M.D.</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>11/16/68</u>			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial			11.19.68		Cedar Hill Cemetery		Suitland Maryland				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Lee Funeral Home. 300. 4th st N E Wash. D.C.						NOV 20 1968					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16207

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16221

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <i>MARY L. Purdue</i>			2a. DATE OF DEATH Month Day Year <i>Nov 18 1968</i>			2b. HOUR <i>3:30 P.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>Cauc</i>		5. DATE OF BIRTH <i>MAR 6, 1889</i>		6. AGE (In years last birthday) <i>79 YRS.</i>	
7a. BIRTHPLACE (State or foreign country) <i>Kentucky</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Althea Woodland Nurs. Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>V</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Del.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>2000 F St. N.W.</i>		14. FATHER'S NAME First Middle Last <i>STERLING B. Nunley</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Ludia BROWN-Nunley</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16b. SOCIAL SECURITY NO. <i>305-32-2500</i>		17. INFORMANT <i>Althea Woodland N.H.</i>		Address <i>1000 Dalview Dr Silver Spring Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Arteriosclerosis</i> <i>4409</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4500</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 years.</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Generalized Debility; Senile Dementia.</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Jul 27, 1964</i> to <i>Nov 18, 1968</i> , that (I) (we) last saw the deceased alive on <i>Nov 16, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Bertram F. Schaefer M.D.</i>				22c. DATE SIGNED <i>Nov. 18, 1968</i>		22d. PHYSICIAN'S NAME (Type) <i>Bertram F. Schaefer</i>	
22e. ADDRESS <i>1780 Mass. Ave. N.W. Wash. D.C.</i>				22f. ADDRESS <i>1780 Mass. Ave. N.W. Wash. D.C.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial/Removal</i>		23b. DATE <i>11/19/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Park Lawn</i>		23d. LOCATION (City or Town) (County) (State) <i>Evansville, Indiana</i>	
24. FUNERAL DIRECTOR <i>Jos/Gawler's Sons</i>		24a. ADDRESS <i>5130 Wisconsin Av., NW Wash. D.C.</i>		25a. RECEIVED BY REGISTRAR <i>NOV 22 1968</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

THE UNITED STATES OF AMERICA

IN SENATE
January 14, 1953

REPORT OF THE
COMMISSIONER OF THE GENERAL LAND OFFICE

ON THE
LANDS OF THE UNITED STATES

IN THE
STATE OF ALABAMA

FOR THE YEAR
1952

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16208 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
Herbert Chester Putnam						Month Day Year			2:07 PM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	
Male	White	February 15, 1936	32 YRS.					Month Day Year	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR	
District of Col.		United States		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery		2:07 PM	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park			Washington San. & Hospital			Electrician			H.M.S. Electric
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Maryland			Prince George's		Adelphi		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1607 Keokee Street
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Herbert G. Putnam			Pearl Hardisty						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No			578 44 7627		Wife--1607 Keokee Street, Adelphi, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Extreme Injuries</u> DUE TO, OR AS A CONSEQUENCE OF <u>with Internal Hemorrhage</u> (b) <u>due to auto accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>8150</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
819.4									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			5:11-17 1968		Deceased driver of car which struck roadside abutment				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
			Street		Marceline Miller Rd., S.S. Montgon Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			M.D.			NOV. 18, 1968			
Belden R. Read M.D.			DEPUTY MEDICAL EXAMINER						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			Nov. 20, 1968		Date of Heaven Cemetery		Edmar. Montgomery Co. Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Takoma Funeral Home - J. J. Watten			254 Carroll NW HC			DATE NOV 19 1968		Charles Judge	

